

WORKING TOWARDS A BETTER
HEALTHIER WAY OF LIFE

97th ANNUAL MOH REPORT

and

SECOND ANNUAL REPORT of the DIRECTOR OF PUBLIC HEALTH

Special Theme:

“The Health of Guernsey Children”

REPORT FOR
THE YEAR 1995/96

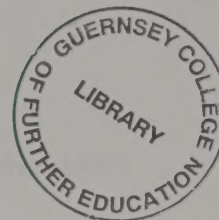
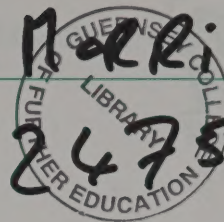
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HEALTH FOR PEOPLE



WORKING TOWARDS A BETTER
HEALTHIER WAY OF LIFE

A.C. Morris

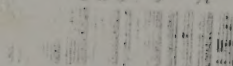


BOARD OF HEALTH

MEMBERS 1995

- President:** Conseiller Mrs S M Plant
- Vice President:** Deputy A A J Bran (until February 1995)
Deputy B Russell (from March 1995)
- Senior Member:** Deputy B Russell (until March 1995)
Mr G V F Birch (from March 1995)
- Other Members:** Deputy O D Le Tissier
Deputy Mrs J Beaugeard
Deputy M J A Barrett
Deputy H R Allen (from February 1995)

WITHDRAWN FROM
STOCK



STATES OF GUERNSEY

BOARD OF HEALTH

Objectives

To maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible by:

- Identifying health needs - now and in the future.
- Planning the future provision of health services to meet these needs.
- Ensuring that the quality of health services provided is high and standards are maintained through careful monitoring.
- Ensuring that only appropriate and effective care or treatment is given, by monitoring the outcome of such interventions.
- Informing people on health matters, promoting a healthy lifestyle and environment.
- Checking that all health services provided are as cost-efficient as possible.
- Promoting managerial and professional excellence within health services.
- Recruiting, training and developing sufficient health care staff to achieve these objectives.

**INTRODUCTORY LETTER
TO THE
BOARD OF HEALTH**

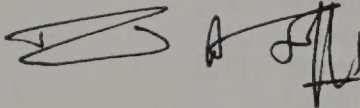
October 1996

The President
States of Guernsey Board of Health

Madam President, Members of the Board

I have pleasure in submitting the Annual Report of the Medical Officer of Health for Guernsey for 1995/1996.

I am, Madam
Your Obedient Servant

A handwritten signature in black ink, appearing to be 'D. Jeffs', written over a horizontal line.

Dr David Jeffs
MEDICAL OFFICER OF HEALTH
Director of Public Health

MEMORANDUM

TO THE BOARD OF HEALTH

(Continued)

1999

It is recommended that the Board of Health be informed of the results of the study conducted by the Health Department in 1998, which showed that the majority of the population in the City of Chicago is in good health.

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- 3. The study was conducted by the Health Department in 1998, and the results showed that the majority of the population in the City of Chicago is in good health.

I have pleasure in submitting the Annual Report of the Medical Officer of Health for the year 1998, which shows that the majority of the population in the City of Chicago is in good health.

- 4. The study was conducted by the Health Department in 1998, and the results showed that the majority of the population in the City of Chicago is in good health.
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HIGHLIGHTS FROM THIS REPORT

Relevant Paragraphs are shown:

- There are increasing demands for both medical practice and health services to become more “evidence based”. Evidence based medicine has been defined as “*the emerging clinical discipline that brings the best evidence from clinic and healthcare research to the bedside, to the surgery and clinic, and to the community*”. Ensuring that clinicians in Guernsey are able to keep abreast of developments in evidence based medicine, and that local healthcare is based on a synthesis of proven best clinical practice remains a challenge for the future [2.4].

- Public Health has been defined as “*that process which gathers, interprets and translates knowledge of health factors amongst the population into effective action*”. The publication of “*Health for Guernsey People*” in 1995 represented a major step in ensuring that public health services in Guernsey were planned and prioritised on the best available evidence [2.5].

- In terms of demonstrated cause of preventable ill health and premature death, the need for the Board of Health to support a tobacco strategy was shown to be paramount. Smoking related diseases are responsible for at least 110 deaths each year in Guernsey.

The costs of treating such tobacco related diseases are also considerable. A package of measures designed to make smoking less attractive and less affordable to the young, and offering practical help to the addicted smoker who wishes to give up was approved by the States of Deliberation in June 1996, but has yet to be fully implemented [2.7].

- There is a popular perception and anecdotal evidence that alcohol abuse also constitutes a major health and social problem in Guernsey, although adequate hard evidence is lacking. The Board of Health therefore intends that local research in this field is conducted during 1996/97, and the findings of this research published as part of the 98th Annual MOH Report [2.8].

- The evidence that 120-150 local women are forced by Guernsey’s 1910 Abortion Law to go to England for termination of an unwanted pregnancy, and often self refer without the benefit of adequate counselling, and the support of family and friends was considered by the Board of Health to be a major social problem. The Board considered that abortion could not be dealt with in isolation, but needed to be related to a package of measures designed to promote responsible sexual behaviour, ensure knowledge, availability and affordability of contraception, and implement other measures necessary to reduce unwanted pregnancy. This package of measures was accepted by the States of Deliberation in June 1996 [2.10].

- Cardiovascular disease control, cervical cancer, other treatable cancers, and substance abuse are other important public health measures to be further developed during 1996/97 [2.11].

- The Environmental Health Department continues efforts to “control those factors in the physical environment which can adversely affect the health and wellbeing of present and future generations”. Such efforts include new and updated environmental health legislation, monitoring important aspects of the physical environment, investigating complaints, answering enquiries, and providing advice [3.2-3.13].

- Guernsey’s public health legislation is based on the 1934 Law and 1936 Public Health Ordinance. New legislation addressing current public health concerns such as the control of pollution must be considered a priority. Such legislation needs to be introduced in the context of an overall environmental health strategy, as has been recommended in the “Environment and Health Action Plan for Europe” published in 1994 [3.14].

- The selection of public health priorities has allowed a systematic and structured approach to health promotion activities. During 1995/96 the Health Promotion Unit has been active in the fields of coronary heart disease prevention, smoking control, reduction in avoidable cancers such as melanoma, drug and alcohol, sexual health, family health, and training areas [4.1-4.10].

- Communicable disease notifications continue to decline, and with the exception of food poisoning are at a historical all time low. Action by members of the Infection Control Committee were effective in controlling several outbreaks of communicable diseases in both hospital and community settings during 1995 [5.8].

- The Board of Health is a major employer, but must work within the “manpower cap” demanded by the States. Reduction in preventable work related injury, illness and absence is an important component of ensuring the most effective use of the workforce within the manpower cap. An Occupational Health Service has been established to help reduce preventable work related injury, illness and absence [6.1-6.3].

- In the 96th Annual MOH Report (1994) the theme “Marriage and Family in Guernsey - an analysis of social trends 1964-1994” was considered in some depth. In this Report, the theme of “The Health of Guernsey Children” provides an opportunity to compare health amongst Guernsey children with their counterparts in England documented in the OPCS publication “*The health of our children*”.

- Important new data is provided on the changing pattern of infant and childhood deaths in Guernsey, results of the first Guernsey School Entry Utilisation Review/Service Satisfaction Survey, and preliminary findings of Guernsey’s participation in the International Study of Asthma and Allergy in Childhood - ISAAC [7.5, 7.10, 7.11, 7.13].

- On this evidence, major improvements in the physical health of children in Guernsey over the past 30 years can be demonstrated. However, there have also been major changes in the social context of childhood, with more mothers choosing to work, choosing to have fewer children, and choosing to have them later in life. There have been significant rises in divorce rates, single parent families, and children born outside marriage. Such changes may be predicted to contribute towards increasing family dysfunction, psychosocial stress in childhood, and overt psychiatric illness manifest by depression, self harm, attempted suicide and suicide amongst the young. A reorientation of child health services may be necessary to cope with these changing patterns of childhood morbidity.

Chapter 1

1.0 Introduction

1.1 Functions of the Annual Report

Welcome to the 97th Annual Medical Officer of Health (MOH) Report, and the Second Report of the Director of Public Health (DPH) for Guernsey.

The change from MOH to DPH is about more than just an additional title - it reflects the changing role of public health in Guernsey, what public health is about, and what it is attempting to achieve.

An Annual Public Health Report must fulfill several functions. It should *inter alia*;

- **Report** “on the state of the public health”
- **Identify** influences deleterious to health
- **Document** public health activity during the previous year
- **Review** progress towards previously set public health targets and objectives
- **Propose** new objectives if there is evidence to suggest these are required
- **Inform** the community of current health trends and priorities
- **Educate** the public regarding current public health concerns
- **Provide** a present and future source of local health reference material.

This Report addresses all these factors to a greater or lesser degree, and in doing so mirrors the changing direction and emphasis within public health in Guernsey.

1.2 About this Report

If a prime function of the Annual Report is to report “on the state of the public health”, it is gratifying to once again be able to state that the “health of Guernsey people” - as measured by traditional health indices, appears excellent.

Notifications of infectious diseases are low, life expectancy is high, and deaths from most major causes continue to decline.

However, there are several areas where there is still plenty of scope to reduce avoidable ill health and premature death even further, and some of these are considered more fully in Chapter 2.

An increasing awareness of the true determinants of better health means that public health must now extend beyond traditional concerns of communicable diseases, environmental and work related hazards.

Individual lifestyle choices such as diet and exercise, broader social influences such as housing and transport, and population concerns such as population density and “healthy public policy” are now recognised as equally important as biological factors in determining the health of our community.

One consequence of adopting this broader approach to promoting better health is that it becomes increasingly difficult to slot such broad trends into narrow twelve month time frames. This Report therefore seeks to reflect the major health concerns of the year, rather than confining itself strictly to events which took place during 1995. The broadening of the title to “MOH Report 1995/1996” reflects this broader approach.

Once again, a section of this Report considers one aspect of health in Guernsey in greater detail. In the 96th Annual Report (1994) the theme of “Marriage and Family in Guernsey - an analysis of social trends 1964-1994” was considered in some depth.

This year the theme progresses to the health of children in Guernsey. In 1995, the Office of Population Censuses and Surveys (OPCS) in England published a Decennial Supplement called “The health of our children”, looking at the changes in child health over a thirty year period.

It therefore seemed appropriate to use this as a basis for examining how the health of children in Guernsey has changed over the past decades, how it compares with that of children in England, and particularly what trends for the future might be predicted.

It is intended that future MOH Reports will also continue to have a major theme, examining in greater depth some aspect of health in Guernsey.

1.3. Acknowledgments

Promoting and maintaining the public’s health is essentially about working with others.

Once again I must acknowledge and record my gratitude to the Board of Health, officers and staff of the Department of Health, my medical colleagues, other States Departments, and the several voluntary organisations and individuals who have continued to support Public Health initiatives in Guernsey and Alderney during 1995/96.

In particular, I would especially wish to thank my Personal Assistant Mrs Maureen Indge for the effort and ability she has again shown in helping to coordinate the various Public Health activities over the year, and particularly for the hard work she has once again devoted to helping compile and produce this Annual Report.

Chapter 2

2.0 Public Health 1995/96

“Public Health is that process which gathers, interprets and translates knowledge of health factors amongst the population into effective action.”

2.1 The “Service Planning” Approach

It has been stated that *“the history of (health) planning in Guernsey is that it has never been given priority compared with the provision of direct operational services. Hence resources were not allocated for data collection, and planning tended to concentrate on buildings rather than services. This led to what is known as disjointed incrementalism; adding bits on what is already there, often on the basis of who shouts loudest.”* [Department of Health “Service Planning Arrangements” 1994]

One consequence of such incremental growth is that there has usually developed adequate *“vertical integration”* - that is links between senior management and *“grass roots”* service providers.

However where services to the same client group are provided from a variety of different health locations (eg hospital, community based, private sector etc), there is often less effective *horizontal integration* (that is links between and across sectors). This may result in poor communication, waste and duplication of resources, and gaps in service provision.

During 1995, the Board of Health embarked on a major planning exercise to take the services it provides forward into the next century. *“Service planning”* is the term used to describe consideration of what provision should be made to meet the healthcare needs of a defined group of people, and to formulating proposals of how to meet those needs, including consideration of relative priorities, resource implications, and the need for both efficiency and effectiveness.

The Board of Health therefore decided to establish a number of *“Service Planning Teams”* to examine and make recommendations on service development within defined areas. These Service Planning Teams differed from previous planning approaches in that they included middle level *“service providers”* (thus ensuring that recent *“hands on”* experience was incorporated in the planning process), and they worked across sectors (thus fostering the development of improved horizontal integration).

The following Service Planning Teams were established, and most have now completed the first round of their planning cycle, contributing to current policy planning proposals. It is anticipated that such input will be further refined as the planning cycle continues into future years.

2.2 Service Planning Teams

- Mental Health Service Planning Team

Sub groups on alcohol abuse, suicide prevention, psycho neurosis, rehabilitation, and services for the elderly with functional and mental illness

- Acute Medical and Surgical Services Planning Team
- Services for Elderly People Planning Team
- Services for People with a Learning Disability Planning Team
- Physical and Sensory Disability Planning Team
- Maternal and Child Health Services Planning Team

The Public Health Directorate has been able to assist several of the above Service Planning Teams by providing the necessary epidemiological data on which sound planning should be based, and by recommending and supporting further research where the necessary base line data has been lacking.

2.3 Defining Public Health Services

A separate Service Planning Team to look specifically at the further development of Public Health services in Guernsey and Alderney was also established at this time. This consisted of representatives of Primary Care, Health Promotion, Environmental Health, Community Nursing Services, the States Analyst, and most recently Occupational Health, as well as the Director of Public Health.

An early challenge was to define how Public Health services differed from other services provided by the Board of Health. Various definitions of Public Health were considered, but several fundamentals were felt to be common to all.

Public Health as a discipline, and as a service;

- involves dealing with *populations* rather than individuals,
- is involved primarily with *prevention*, whether at a primary, secondary or tertiary level,
- is (or should be) *evidence based* and *data driven*,
- involves “*intersectoral collaboration*” - working with others, particularly those in Government, and often through a legislative approach,
- requires working for and with the community, *building “healthy alliances”* and encouraging “*community participation*” in health.

Using these criteria, the Team will continue to meet to consider relative public health priorities, and further recommend how these relate to, and are integrated with the wider health spectrum.

2.4 Evidence based health priorities

The evolving nature of healthcare means that newly coined words and phrases are constantly being added to the medical vocabulary. 1995 was undoubtedly the year in which “evidence based” attained wider popular currency. As well as the ubiquitous “evidence based medicine”, with a journal of this title (first published in November/December 1995), there has been a move towards encouraging better “evidence based prescribing”, and “evidence based purchasing” within the National Health Services “internal market”.

Evidence based medicine has been defined as *“the emerging clinical discipline that brings the best evidence from clinical and healthcare research to the bedside, to the surgery and clinic, and to the community”*. Sackett D, Haynes L “The case for evidence based medicine” Evidence Based Medicine 1995 1.1.5

It is pointed out that clinicians need new clinically important evidence as often as twice for every three patients seen, affecting up to eight clinical decisions a day. To achieve this, it has been calculated that general physicians would need to read nineteen original articles each day, 365 days per year, if they wanted to keep abreast of their field.

Ensuring that clinicians in Guernsey are able to keep abreast of developments in evidence based medicine, and that local healthcare is based on a synthesis of proven best clinical practice remains a challenge for the future.

However, a start has now been made on ensuring that more comprehensive, relevant, and timely data is available to guide the health planning process.

2.5 “Health for Guernsey People”

In July 1992 the Government White Paper “The Health of the Nation - a strategy for health in England” was accepted by Parliament. This document;

- selected five key areas for action,
- set national objectives and targets in these key areas,
- indicated the action needed to achieve these targets,
- outlined initiatives to help implement the strategy,
- set a framework for monitoring, development, and review.

In March 1995, the Board of Health published “Health for Guernsey People”. For the first time in recent years, health data from both Board of Health sources, other States Committees, and from community based groups was presented in a comprehensive and integrated way. Health and health related factors in Guernsey were also compared with those of England, Jersey, France and other European and English speaking countries. Targets for “health gain” were also set in line with England’s “Health of the Nation” targets.

2.6 Guernsey Health Promotion Priorities

This improved health data has also allowed the selection of “evidence based” health promotion priorities. These have been selected on the basis that;

- the condition was a major cause of mortality or morbidity on Guernsey,
- effective interventions were available.
- It was likely that measurable results would be achieved within a defined timespan.
- That comparison was possible with the “Health of the Nation” targets or with other published material.

The health promotion priorities recommended in “Health for Guernsey People” may be summarised as follows;

● Major Health Priorities

- Reduction in tobacco related illness
- Reduction in cardio-vascular disease
- Prevention of malignant melanoma
- Control of alcohol abuse
- Reduction in child injuries

● Other Health Priorities

- Reduction in breast cancer
- Reduction in cervical cancer
- Promotion of sexual health, control of HIV and other STDs
- Prevention of substance abuse
- Improved prevention of suicides
- Promotion of breast feeding

● Other Important Public Health Issues

- Reduction in asthma morbidity
- Reduction in diabetes morbidity
- Reduction in other treatable cancers
- Improvements in children’s dental health

2.7 The Need for a Tobacco Strategy

The “Health of the Nation” concludes that *“smoking remains the largest single cause of preventable mortality in England”*.

The evidence presented in “Health for Guernsey People” reveals that the adverse health consequences of smoking related disease are possibly even greater in Guernsey than in England. On the evidence available, it would appear that smoking contributes to between 110-130 deaths from smoking related diseases in Guernsey each year. Using accepted if somewhat conservative criteria, these may be estimated to include;

- 90% of all lung cancer deaths - estimated average 40 deaths annually in Guernsey.
- 76% of all deaths from bronchitis/emphysema - estimated average 20 deaths annually in Guernsey.
- 50% of all deaths from cancers of the lip, larynx, oesophagus, pancreas, stomach, cervix, kidney, bladder - estimated 20 deaths annually in Guernsey.
- 18% of all deaths from ischaemic heart disease - estimated average 24 deaths annually in Guernsey.
- 11% of all deaths from stroke - estimated 6 deaths annually in Guernsey.

From UK studies, it is estimated that half of all smoking related deaths occur in middle age (35-69 years), and half in old age (70 years and above). Those dying in middle age (35-69 years) lose an average of 20-25 years of life compared with lifetime non-smokers.

It is further pointed out that tobacco is the only product on the market that kills and injures its users when used exactly as intended by the manufacturers. The development of diseases leading to poor health and premature death in 50% of all regular users would not be tolerated by the community in relation to any other consumer product.

The Board of Health was aware that most regular smokers have taken up the habit in their early teens, and often before the legal age for tobacco purchase. The reasons why children and young people take up smoking are multifactorial and complex, but what is certain is that tobacco is highly addictive, and that most established smokers who try to quit the habit fail. The Board of Health therefore believes that the key to reducing the continuing burden of tobacco related disease must lie in persuading young people against becoming regular and addicted smokers.

The Board of Health has adopted as its Mission or primary objective *“to maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible.....”* [Board of Health Objectives].

It would be impossible to achieve this without doing everything possible to reduce smoking related disease - the biggest single cause of preventable ill health and premature death in Guernsey.

In February 1995, the Board of Health therefore agreed to adopt a comprehensive tobacco control strategy. To achieve this would need an integrated and coordinated programme involving political, legislative, financial, educational and social approaches.

The States have previously voted to follow Britain's example in favouring a Voluntary Agreement on Tobacco Advertising, and two Joint Agreements have been negotiated between the Health Authorities of Guernsey and Jersey, and the Channel Island Tobacco Importers Association (CITIA). The most recent Joint Voluntary Agreement was due to be replaced by a third joint agreement to be effective from 31 December 1995.

The Board of Health took the view that because of the evidence suggesting a greater adverse impact of smoking on health in Guernsey, compared with England, the local Agreement should substantially extend restrictions contained in the current British Agreement. During 1995, despite over eight months negotiation between the Health Authorities of Guernsey and Jersey and CITIA, the Tobacco Industry had shown itself unwilling to make any major concessions in further restricting tobacco advertising in the Channel Islands, which had not already been included in the UK "Voluntary Agreement on Tobacco Products, Advertising and Promotion" negotiated in 1994.

The Board's efforts to introduce a more comprehensive approach to tobacco control, and especially at dissuading young people from becoming regular and addicted smokers was given further focus by an Amendment agreed at the 1995 States Budget Debate.

This directed *"the States Board of Health to investigate the effect which alcohol and tobacco advertising has on encouraging people, particularly young people, to smoke tobacco and drink alcohol, which investigation shall include consideration of whether an increase in duty on alcohol and tobacco should be recommended annually in the future budgets."*

The Board considered that the evidence on the adverse health effects of smoking was overwhelming, and brought forward a package specifically to discourage smoking, especially amongst young people [Billet D'Etat XII 1996].

These included recommendations to;

- introduce a total ban on all public advertising of tobacco and tobacco products except a point of sale. Imported print media would be exempt;
- increase the size and content of pack warnings as originally proposed in the Draft Voluntary Agreement on Tobacco Advertising;
- amend the 1913 Tobacco Ordinance to raise the minimum age for the legal purchase or possession of cigarettes and tobacco products from 16 to 18 years;
- increase the level of duty on tobacco and tobacco products by a minimum of £20 per kilo at least from 1 January 1997;
- additionally, increase the level of duty on tobacco and tobacco products by at least 8.5% per annum in real terms in future budgets for a minimum of five years commencing 1 January 1998;

- maintain and increase a range of Health Promotion activities designed to help addicted smokers break their addiction, to support school and community based programmes designed to discourage young people from smoking, and to promote a better healthier way of life generally.

In the event, all these recommendations have been accepted by the States, but have yet to be implemented.

However, once these reforms are in place, Guernsey will be in a strong position to continue to monitor the import and consumption of tobacco and tobacco products. A further five yearly Census of population was conducted in April 1996, and further health surveys of adults through Family Practitioners, and young people through secondary schools are planned once up-to-date denominator data is available.

With this information, it should be possible to demonstrate the effectiveness of this recently approved package of measures in reducing smoking rates and levels, especially amongst the young - an important opportunity for demonstrating the value of a coordinated range of control measures.

It is hoped that taken in combination, the effects of the individual measures will be greater than those demonstrated in other jurisdictions which have introduced such reforms in a less coordinated manner. Demonstrated success in reducing smoking rates and levels amongst young people must in time impact beneficially on the health of the whole Island.

2.8 The Health Impact of Alcohol

There is a large body of well researched scientific study to demonstrate the relative risks of the various diseases which have been linked with smoking, to the beneficial effects of giving up smoking, and to the benefits of restricting advertising and increasing price as effective ways of helping reduce smoking rates, and their associated health consequences.

The position is less clear with regard to alcohol. Although there are well recognised adverse health and social consequences associated with excessive or irresponsible consumption of alcohol, it is now accepted that there may be some health benefits from moderate alcohol intake.

A phenomenon known as the “J shaped curve” suggests that overall mortality is higher amongst those who never drink, and amongst heavy drinkers, than amongst those who drink regularly and in moderation. However, controversy continues in both Government and many medical circles regarding what may constitute a “safe and beneficial” level of alcohol intake.

Scientific evidence on the influence of advertising, price and alcohol consumption is less well researched than that relating to tobacco. There is also a lack of reliable local information on what influences Guernsey drinkers, especially young people in their choice of drink, patterns of drinking, and levels of consumption.

The Board of Health has therefore determined to postpone bringing a second report to the States on the effects of alcohol, and the possible health benefits of restrictions on advertising, or of increasing the price of alcohol until the necessary local research has been performed.

A Working Party has already been convened, focused local research is planned for 1997, and it is anticipated that a detailed analysis of the impact of alcohol on health in Guernsey will be contained in the 98th Annual Medical Officer of Health Report.

2.9 Reducing Deaths from Breast Cancer

“Health for Guernsey People” revealed that breast cancer was the single most common form of cancer amongst Guernsey women, responsible for 18.5% of all cancer deaths. There were 72 deaths registered as being due to breast cancer between 1989 and 1993 in Guernsey. Reducing breast cancer morbidity and mortality must therefore be accepted as an important local health priority.

Because of the uncertainty as to the true cause of breast cancer, the best hopes for reducing breast cancer deaths is in secondary prevention through an effective breast screening programme. The Board of Health therefore contracted with BUPA to provide a breast screening service from a mobile unit located in the grounds of the Princess Elizabeth Hospital, commencing October 1992. During the first (prevalent) round screening, some 6,735 local women attended for mammography, and 104 cancers were detected, of which 35 (37%) were below 10mm in size, and therefore most amenable to successful treatment.

The Guernsey Board of Health officially took over the Guernsey Breast Screening Programme from BUPA on 1 January 1995. Following completion of the new Unit at the Princess Elizabeth Hospital, the first women for re-screening were called in March 1995.

Between March 1995 and February 1996, a total of 2,856 women have been invited to attend for screening/re-screening, of whom 2,795 (97.8%) attended. This is well above the NHS standard of >75% attendance.

Of the 2,795 women who attended;

- 92 (3.3%) were <50 years
- 1,588 (56.8%) were 50-64 years
- 2,372 (85%) were 50-74 years
- 331 (11.8%) were >75 years

Unlike the NHS, Guernsey does not have a whole population register, and the basis for recall is therefore only those women invited by the GSSA who attended for first round screening, plus those known to the GSSA to have turned 50 during the course of 1995, plus those who had picked up leaflets at their Doctor's surgeries, and made their own appointments, or have been asked to attend by their Family Doctor.

Since the ultimate success of a screening programme depends on whole population participation, it will not be possible to say how successful rescreening has been until after the completion of the second (incident) round (estimated February 1997). Those actually participating can then be compared against whole population estimates obtained from the 1996 Census, in order to calculate total population participation rates.

Even high population participation rates will not ensure a reduction in breast cancer mortality unless the Programme maintains well defined quality assurance standards. At implementation of the Programme, it was agreed that Guernsey Breast Screening should equal or better the NHS Breast Screening QA Indicators.

During second round screening to date;

- 189 women (6.8%) have been recalled for assessment [NHS Standard <7%]
- 20 women (0.7%) have had biopsies performed [NHS Standard <0.35%]
- 11 cancers (7.16/000) were detected [NHS Standard >3.5/000]
- of these 4 (14.3/000) were <10mm [NHS Standard >15/000]

It should be noted that the NHS programme only invites women 50-64 years for screening, so a direct comparison is not possible.

QA Indicators taken during the course of a screening programme may also be misleading. However, the Indicators to date compare favourably with NHS standards, and also with those obtained from Wessex (1994) and Jersey (1990-95). This is perhaps a more relevant comparison in that they are sociodemographically more comparable populations.

It is also of interest that the Sixth Guernsey Clinical Research Fellowship awarded by the Wessex Medical Trust in 1995 went to a team from Southampton who will be researching the familial basis of breast cancer amongst Guernsey women. The project is expected to last two years.

2.10 Contraception, Unplanned Pregnancy and Abortion

A more “evidence based” approach to health also raised the issue of whether the Bailiwick’s 1910 “Loi Sur L’Avortement” (Abortion Law) which makes assisting or attempting to procure an abortion unlawful in most circumstances still met the needs of the Island.

Data from the Office of Population Censuses and Surveys (OPCS) in England show that each year between 120 and 150 local women travel to England in order to obtain an abortion. They generally arrange the abortion at their own expense, frequently without the support of family and friends, and often without the benefits of counselling. The Board of Health considered that this was a major social problem, which needed to be addressed.

The Board however felt that the problem of women having to leave the Bailiwick in order to obtain an abortion could not be addressed in isolation. All efforts to promote responsible sexual behaviour, ensure knowledge, availability and affordability of contraception, and all other means necessary to reduce unwanted pregnancy also needed to be taken.

In March 1994, the Board therefore set up a Working Party to report on the issues of contraception, unplanned pregnancy and abortion. Known as the CUPA Working Party, it was asked to review existing services in these areas, to consult with the public, and to make recommendations to the Board of Health on future developments.

The Board of Health agreed to publish the Report of the Working Party in the form of a public discussion document in November 1995. The public discussion document contained 23 recommendations concerning increasing contraceptive knowledge and availability, promoting education and prevention of unplanned pregnancy, and proposals clarifying the circumstances when abortion might lawfully be performed in the Bailiwick.

An analysis of submissions received in response to the discussion document showed there was widespread public support for a range of measures to reduce the likelihood of unplanned and possibly unwanted pregnancies within the Bailiwick. In particular there was support for increasing Personal, Social and Health Education (PSHE) taught in Island schools, and further extending this to independent schools, College of Further Education, and to other venues for young people within the community.

There was also widespread support for increasing knowledge, accessibility and affordability of the various means of contraception. On the subject of abortion, there was a wide spectrum of opinion expressed, with a number of submissions arguing passionately that abortion should remain unlawful in Guernsey, whilst others argued that the recommendations did not sufficiently liberalise access to abortion.

The Board of Health therefore decided to largely accept the original recommendations of the Working Party, and these were submitted to the States in the form of a Policy Letter in May 1996 [Billet D'Etat VIII 1996]. In June 1996, the States agreed to support all the Board's propositions.

Although yet to become law, the Board of Health believes that when fully implemented, these proposals will have the effect of further promoting more responsible sexual behaviour, especially amongst the young, and thereby further reducing the number of unplanned and unwanted pregnancies.

The Board also believes that the proposed clarifications of the law will ensure that independent and objective counselling is available to women faced with an unplanned pregnancy, and that many women will feel better able to take the most appropriate decisions for their own particular circumstances with this support.

The Board considers that even with these changes, some Guernsey women for reasons of confidentiality or preference will continue to seek a lawful abortion in the United Kingdom or elsewhere. The Board of Health therefore does not believe that there will be a large number of abortions performed at the Princess Elizabeth Hospital, but under the proposed new law, these will be carefully monitored.

However, the Board believes that taken together, the proposed changes will address the undeniable social problem of women being forced off the Island to obtain a legal abortion without the benefits of counselling, and will help ensure that as far as possible all pregnancies are wanted, and that babies will be born into a secure and loving environment.

2.11 Some Public Health Challenges Ahead

The more “evidence based” approach to public health planning arising from the improved health data contained in “Health for Guernsey People” has led to the selection of a group of defined health priorities, as outlined in Section 2.6 above.

As part of a more strategic approach to public health, these are now being tackled in a systematic way. During 1996/97, it is hoped to demonstrate further progress in the areas of cardiovascular disease, cervical cancer, other treatable cancers, and in substance abuse as follows;

● Cardiovascular Disease and Obesity

Being overweight, together with genetic factors, smoking behaviour, blood fats, and blood pressure are recognised major risk factors in the development of cardiovascular disease.

BMI is an index of overweight and obesity calculated by dividing weight in kilogrammes by height in meters squared. Having a BMI >25 is regarded as being overweight, whilst having a BMI >30 is defined as being obese.

The Guernsey Lifestyle Surveys have shown that adult males having a BMI greater than 25 has risen from 50% in 1988 to 52% in 1993, whilst amongst Guernsey women, those with a BMI greater than 25 has risen from 41% in 1988 to 49 in 1993.

Thus over 50% of Guernsey adults may be defined as being overweight ie having a BMI >25.

Similarly obesity (BMI >30) has increased amongst Guernsey men from 5% in 1988 to 11% in 1993. Amongst Guernsey women, obesity has increased from 13% in 1988 to 16% in 1993.

The “*Health of the Nation*” has set the target;

“To reduce the percentages of men and women aged 16-64 who are obese by at least 25% for men and by at least 33% for women by the year 2005” [from 8% for men and 12% for women in 1986-87 to no more than 6% and 8% respectively in 2005].

A joint publication between the Health Education Authority and the Office for National Statistics, entitled “*Health in England 1995*” shows that lack of physical activity, rather than gross overeating is the major cause for overweight and obesity in most British people. The amount of food people eat has been slowly reducing, but levels of physical activity have fallen even more.

The steady fall in heavy manual work, more sedentary leisure activities such as watching television, and the use of private motor vehicles for even short journeys all contribute towards this. However, the Government publication “*More people more active more often*” concludes that a major factor inhibiting regular exercise in Britain is the perception that “exercise is only for the fit”. This in turn has led to campaigns such as the “30 minute Olympics” encouraging increased levels of physical activities in a range of everyday activities.

Increasing levels of physical activity in Guernsey as a means of decreasing the cardiovascular risks of obesity must remain a health priority in Guernsey.

During the early part of 1995, the “Flab Busters” campaign was successful in using the mutual support of a team approach to increase sensible eating and activity levels to encourage weight loss amongst participating groups.

It is intended that activities to encourage “more people more active more often” will again be promoted during 1996/97.

● Better Preventing Cervical Cancer

“*Health for Guernsey People*” demonstrated that cancer of the cervix and uterus was the fourth commonest cause of female cancer death in Guernsey, and the fourth commonest cause of potential years of life lost from all causes in Guernsey women aged less than 75 years. Rates of cervical cancer mortality in Guernsey would appear to be somewhat above those in Jersey, and many other parts of Europe, but less than Britain, which has the second highest rate of cervical cancer in Europe. However, although “five year means” were used, the small number of cervical cancer deaths overall means such comparisons need to be interpreted with caution.

Cancer of the cervix appears to be related *inter alia* to exposure to the Human Papilloma Virus (HPV). It is a relatively slowly growing cancer, and the best hope for reduction in cervical cancer morbidity and death lies in cervical screening of a higher proportion of the population at optimum intervals (3-5 years), rather than the screening of a lesser proportion more frequently.

Over recent years, although Guernsey has developed a cervical screening service, it does not have a formal cervical screening programme. Despite an increasing demand from Family Practitioners for cervical screening at more frequent intervals, cases are still being discovered of cervical cancer in women who have never been screened, or who have not attended for screening for many years. To achieve a reduction in avoidable morbidity and mortality from cervical cancer will require;

- Adherence to NHS Cervical Screening Programme Guidelines.
- Compliance with NHS Quality Indicators.

Because of small numbers locally, off-Island reporting may need to be considered if these indicators are to be met. This already occurs with mammograms in the Guernsey Breast Screening Programme.

- Establishment of a “Population Register” for call/recall of women in the target age group (20-65 years).

This may require an integration of current Family Practice based systems, or possibly adopting a similar strategy to breast screening, where the Guernsey Social Security Authority (GSSA) database was used for initial invitations.

- Further laboratory computerisation.

Progress towards implementing a cervical screening programme must remain a priority for 1996/7.

● Other Avoidable Cancers

Progress has already been made in tackling major sources of cancer mortality, particularly cancer of the lung in males, and cancer in the breast, lung and cervix in females.

Cancer is responsible for over 28% of all Guernsey deaths, and there are many other cancers of importance, including cancers of the lower bowel, prostate, stomach, oesophagus, pancreas and the various forms of leukemia in Guernsey men, and cancers of the lower gut, pancreas, stomach, oesophagus and the various forms of leukemia in women. However, the number of cancer deaths from any of these causes tend to be low on an annual basis, and the need for the establishment of a Cancer Registry was highlighted in "Health for Guernsey People".

This need was reiterated in the 1994 95th Annual MOH Report, and during 1995, successful discussions were held with the Wessex Cancer Intelligence Unit, and the States of Jersey on the need for a uniform approach to cancer registration across the Channel Islands.

The Health Authorities in Jersey have agreed to transfer their existing data from the Thames Cancer Registry and it is intended to extend the collection to include registrations from Alderney. All data would be held by the new South and West Cancer Registry, which would allow comparisons between the Islands, and with comparable mainland populations.

Successful cancer registration will ultimately depend on high levels of communication and collaboration between Public Health staff, the Laboratory, clinicians in both Specialist and Primary Care practice, and with the Cancer Registry itself.

High quality cancer data is essential to evaluate the success of prevention and screening programmes, and the effectiveness and outcomes of treatment. If we wish to demonstrate the quality of services provided, such data must be considered essential.

● Minimising Drug Related Harm

In July 1993, a major Policy Letter entitled "Substance Misuse in Guernsey reducing dependency upon drugs, tobacco, alcohol and other substances" was brought to the States by the Board of Health [Billet D'Etat XIV 1993].

Amongst its recommendation was a requirement for the States Board of Health to be authorised to periodically review the membership and scope of the Dependency Sub Committee.

In 1994 the Department of Health in England published "*Tackling Drugs Together*", whilst in 1995 the Health and Social Services Committee of the States of Jersey published a report on "*The Misuse of Drugs*". These publications cover remarkably similar ground, albeit on differing scales.

Amongst their recommendations are the requirements for a top level intersectoral group at a senior level to develop policy, for a senior officer group to ensure effective policy implementation, and for a senior officers' support group responsible individually to their respective Chief Officers for the day to day management of drugs related services. In the English document, it was suggested that such coordination should occur at a local level, as "drug reference groups".

Guernsey is fortunate in that Drug Concern, an independent community based charity was established in 1991, and has been successful in bringing together the various States Committees who have responsibility in part for tackling the drug problem. These include Police, Customs, Prison and Probation Service, Education, Board of Health etc.

The stated objectives of Drug Concern are;

- Establishing the extent and nature of the use of illegal drugs in Guernsey.
- Increasing public awareness of the growing misuse of drugs.
- Providing support and counselling services for those affected by drug abuse.

Drug Concern has been remarkably successful in raising public awareness of the scale and importance of the drug problem in Guernsey. Following the appointment of a full time Project Manager in 1994, Drug Concern has been able to broaden its range of activities to include a number of "harm minimisation" approaches amongst addicted intravenous drug abusers on the Island.

However, it is important that a small community based organisation with limited resources such as Drug Concern does not attempt to overextend these resources, by taking on responsibilities which would be better performed by other agencies. An independent "management review" of Drug Concern by an outside consultant will help clarify the most effective function(s) for Drug Concern.

In the meantime, the Dependency Sub Committee of the Board of Health will be carefully examining the recommendations contained in *"Tackling Drugs Together"* and *"The Misuse of Drugs"* and deciding whether the strategies recommended in these publications have any relevance to Guernsey, and if so how they can best be implemented.

Three Working Groups have been established with the following mandates;

- Import Restriction and Enforcement.
- Education and Health Promotion.
- Treatment and Rehabilitation.

It is expected that the Dependency Sub Committee will received the reports of these Working Groups during 1996, with possible implementation during 1996/97.

2.12 Health and the Health Insurance Scheme

In *“Health for Guernsey People”*, it was pointed out that environmental and social factors, along with lifestyle choices were as important as the provision of health services in ensuring the health of the population.

However, equality of access to health services is also an important public health consideration, and during 1995 negotiations were conducted between the Guernsey Social Security Authority, the Board of Health, and the Medical Specialist Group leading to proposals for the Health Insurance Scheme being accepted by the States in June 1995. The scheme itself was introduced on January 1st 1996.

Broadly this provides for Specialist medical care at a defined level (the range of services provided during 1994) for the whole resident population, at no direct patient cost at the point of delivery. The scheme is underwritten by increased contributions to the Guernsey Social Security Authority (GSSA), related to income. One innovative feature is that a “fixed price contract” for a seven year term has been negotiated. It can be said with some truth that Guernsey is the first (and probably the only) country in the Western world which can predict with some certainty its likely costs for secondary healthcare over the next seven years.

The details of the scheme will be well known to most Guernsey residents through extensive media coverage at the time of the States Debate in June 1995, and by continuing information and promotion by the Guernsey Social Security Authority.

One component which will perhaps be less well known is the requirement for a much enhanced level of health service activity recording. The need for “improving the appropriateness and effectiveness of clinical interventions” was mentioned in the 1994 96th Annual MOH Report as part of the role of Directors of Public Health in the reorganised NHS in Britain, and a likely direction for future developments in Public Health in Guernsey.

The more comprehensive and more accurate health statistics now available as a consequence of the Health Insurance Scheme will allow Guernsey to compare the range and variety of health services being delivered with the demonstrated health needs and priorities of our population, to ensure the best “health for Guernsey people”. This will become of increasing importance during the lifespan of the present contract.



Chapter 3

3.0 Environmental Health Department

3.1 Introduction

The objective of the department remains that of controlling those factors in the physical environment which can adversely affect the health and well being of present and future generations.

To achieve this objective, environmental conditions are monitored, assessed, corrected and controlled, where possible.

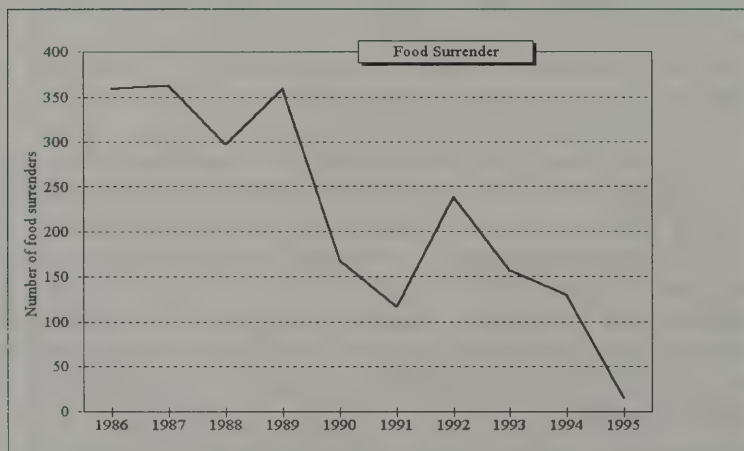
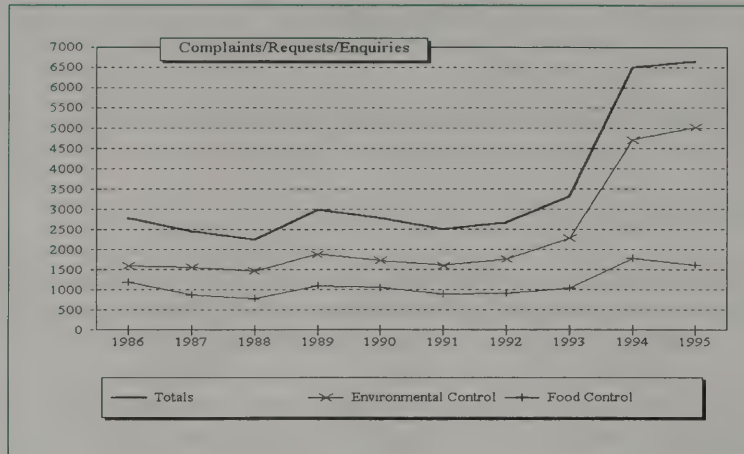
A Technical Assistant was appointed to the department during the latter part of the year. This appointment will facilitate the increasing environmental monitoring role of the department and results from the recognition that decisions which affect the environment need to be based upon sound background data.

To ensure that the quality of service and the methods of working conform to current recognised standards the Environmental Health Officers have to undergo Continuing Professional Development to maintain their professional status as members of The Chartered Institute of Environmental Health.

3.2 Legislation

Slow progress continued to be made during the year on the development of Control of Environmental Pollution legislation. It was not possible, however, to present the policy letter to the States of Deliberation but a consultation document will be circulated to all interested parties during 1996.

Considerable progress, however, was made with relation to food legislation with the introduction of The Food and Drugs (Food Hygiene) (Amendment) Order, 1995 and The Food and Drugs (Labelling of Food) Order, 1995, which came into force on the 1st August and the 1st October respectively. In addition, The Food and Drugs (Amendment) (Guernsey) Law, 1995 and The Food and Drugs (Registration of Food Premises) Order, 1995 were also approved but these will not come into force until the early part of 1996. Although the environmental health officers will continue with their endeavours to improve the standard of food hygiene by persuasion and education, the new law will enable them to take immediate formal action against a food trader when there is an imminent risk to public health. Prior to the introduction to the amendment to the Law, the officers have had to rely on Court action, with its inevitable delays, before the safety of the public could be assured.



3.3 **Complaints/Requests for Advice/Enquiries**

A total of 6637 complaints, requests for advice or enquiries were received during the year: an increase of 140 over those recorded in 1994. Whilst the Food Section, with a total of 1617, showed a decrease of 169, the Environmental Control Section, with 5020, recorded an increase of 309. The details are shown in the tables and the graph on the following page.

Food Safety and Infection Control

Food Condition	151
Food Poisoning	362
Food Safety	653
Food Surrender	84
Miscellaneous	367
Totals	1617

3.4 **Food Safety and Infection Control**

There were 1617 complaints/requests dealt with during the year. Details are shown in the table and graph.

3.5 **Food Complaints**

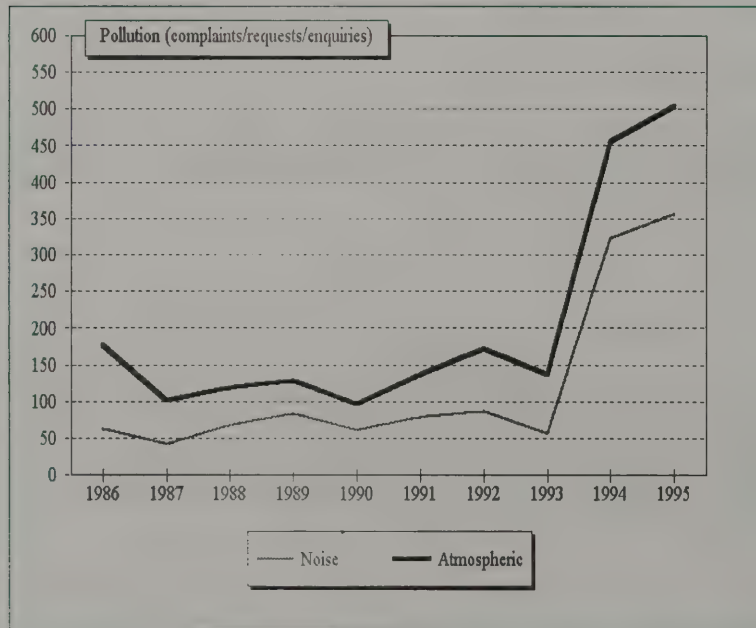
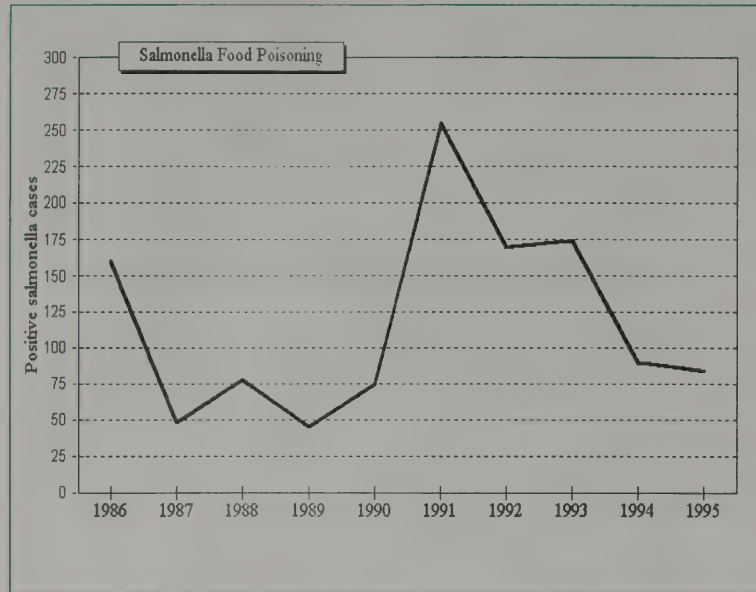
40 complaints were made to the department during the year regarding the condition of food purchased. All complaints were dealt with informally.

3.6 **Food Surrender**

The Board of Health’s policy of charging for the issue of food surrender certificates came into force on the 1st January 1995. As expected, the number of certificates issued was drastically reduced. A total of 15 certificates were issued (130 in 1994) thus releasing valuable officer time.

3.7 **Education**

The Environmental Health Officers continued to promote the Chartered Institute of Environmental Health’s Basic Food Hygiene Certificate Course. A total of 39 candidates attended a total of 6 courses run by the department during the year. 38 candidates successfully completed the examination.



3.8 Food Poisoning

The department received notification of 84 confirmed cases of Salmonella food poisoning during the year together with a further 56 confirmed cases of Campylobacter. All cases of Salmonella were fully investigated by environmental health officers. Apart from one outbreak involving 11 persons who had eaten Baked Alaska at a local restaurant, all the other incidents were classed as individual cases or small family outbreaks. Details can be found in the following table and graph.

Salmonella type/Origin	Guernsey	UK	Abroad	Unknown	Totals
Enteritidis phage type 4	59	1	1	4	65
All others	10	1	8		19
				Total	84

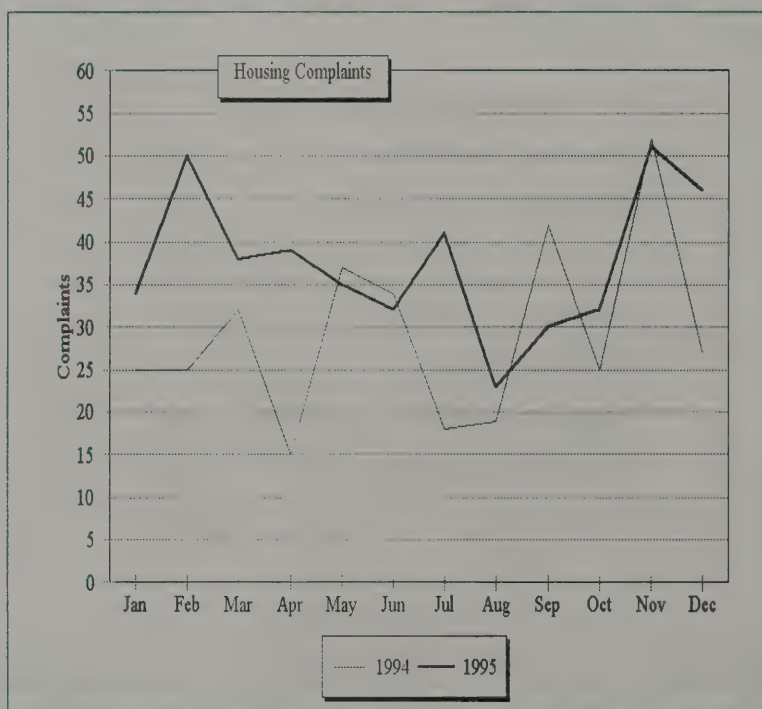
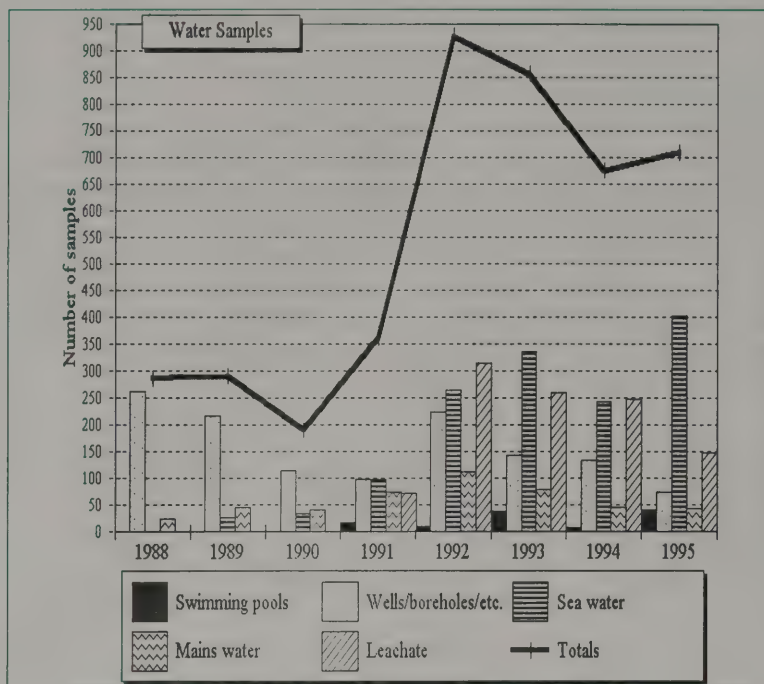
3.9 Control of the Physical Environment

A total of 5020 complaints/enquiries/requests were dealt with during the year. Details are shown in the following table and graph.

Environmental Control

Housing Conditions	451
Pollution - Atmospheric	503
Pollution - Land/Water	478
Pollution - Noise	357
Rats/Mice/Pests	1605
Water Samples	566
Miscellaneous (General)	1060
Totals	5020

Once again there has been an increase in the number of complaints. Members of the public are increasingly being denied their right to enjoy their surroundings without being subjected to noise or atmospheric nuisance. Unless those causing nuisance can be persuaded voluntarily to desist it will be necessary to rely on appropriate legislation being introduced.



3.10 Water Sampling

The following samples were taken for bacteriological and/or chemical analysis during the year:

Swimming Pools	41
Wells/boreholes	74
Sea Water	404
Mains Water	43
Leachate	147
Totals	709

3.11 Rodent and Pest Control

A total of 644 complaints or requests for assistance were dealt with during the year and a total of 1324 treatments were carried out by Rodent Control staff. The department continued with its programme of the systematic treatment of bays and headlands around the Island and staff carried out 684 treatments during the year.

3.12 Housing Conditions

A total of 451 complaints of unsatisfactory conditions were received during the year. Complaints were mainly concerned with unsatisfactory living conditions, overcrowding, dampness and defective drainage. The following graph shows the frequency of complaints:

3.13 Air Quality Monitoring in Guernsey

The department continues to monitor sulphur dioxide and nitrogen dioxide levels. One site near the Vale Power Station monitors sulphur dioxide, whilst a further 4 sites have been added to the existing 5 sites monitoring nitrogen dioxide.

Measured levels of sulphur dioxide continue to be very low, with a monthly average below 10 ppb (parts per billion) and peak levels rarely exceed 25 ppb. Air quality is classified as “Very Good” at levels below 60 ppb, based on the United Kingdom Department of the Environment’s Air Quality Bandings.

Nitrogen dioxide monitoring is carried out in conjunction with the United Kingdom National Survey. The highest levels being reached in Fountain Street, St Peter Port, with a monthly average of 20.28 ppb and a peak (in August) of 26.18 ppb. Lowest levels are found in rural areas with La Passee averaging 6.33 ppb and Corbiere averaging 3.86. Levels below 50 ppb indicate “Very Good” air quality, again based on the Air Quality Bandings.

The Environmental Health Department continues to evaluate “real time” monitoring equipment for a wider range of pollutants. The results generated by the use of such equipment will be beneficial to a number of States Committees and would enable the department to safeguard the Island’s “Very Good” air quality.

Nitrogen Dioxide Survey Results

Site	1992	1993	1994	1995
College Street	17.42	15.36	14.03	14.91
Princess Elizabeth Hospital	5.74	9.86	6.83	7.69
Nr Corbiere	3.32	5.52	3.62	3.86
South Side	8.79	14.80	12.15	13.58
La Passee	6.57	7.16	6.37	6.33
Fountain Street				20.28
Commercial Arcade				9.47
Albert Square				14.16
Trinity Square				13.82

Results in parts per billion



Indicates results incomplete for the year

3.14 Developing an Environmental Health Strategy

The origins of public and environmental health in Guernsey date back almost exactly 100 years, when a major diphtheria epidemic hit Guernsey. In 1899 there were 121 cases of diphtheria, and 23 deaths. Guernsey’s first Medical Officer of Health Dr John Brownlea MD DPH was appointed in 1899 as part of a range of measures introduced by the States to combat and control the epidemic. The States Board of Health was also officially established on 29 December of that year.

However, there was continuing reluctance by the States to allow the newly established Board of Health to take responsibility for public health measures throughout the Island, and sewage, refuse collection and disposal, and other sanitary measures still resided firmly with the Parish Constables.

It was not until 1934 that the States agreed to the “*Loi Relative a la Sante Publique*”, which was complemented by the Public Health Ordinance of 1936. This legislation remains the mainstay of public and environmental health control in Guernsey to this day.

This legislation essentially mirrors the English Public Health Act of 1875 and provides *inter alia* for;

- Notification of disease.
- Prevention of spread of infection.
- Inspection of food, farms and dairies.
- Abatement of nuisance.
- Emergency powers.

A review of public health legislation as it applies to the environment is obviously long overdue in Guernsey, and the Environmental Health Department has been working to finalise “Control of Environmental Pollution” legislation over recent years. However, legislative reform needs to be seen in a wider context.

The “Second European Conference on Environment and Health” organised by the European Regional Office of the World Health Organisation, was held in Helsinki in June 1994. It was attended by Health and Environment Ministers of over 50 countries.

The Conference agreed on an “Environment and Health Action Plan for Europe” (EHAPE) a principal feature of which was that environment and health departments in individual countries would jointly prepare their own national Action Plans by the end of 1997.

The UK was one of six countries which agreed to act as a pilot, and following wide consultation, the UK “National Environmental Health Action Plan” was launched in July 1996.

Environmental influences on health are no respecters of boundaries, and being an island cannot isolate Guernsey from the environmental pressures of the 1990’s, anymore than it prevented the arrival of diphtheria in the 1890’s.

Representatives of the Environmental Health Department are already contributing to a series of Working Groups set up by the Advisory and Finance Committee to develop a strategic approach to a range of issues including pollution control, energy and transport policy.

A “Guernsey Environmental Health Action Plan” will also be developed during 1997 in parallel with this work to ensure that the work of the Environmental Health Department contributes to and complements that of other States Committees, thus ensuring the best use of limited Environmental Health resources, minimising adverse environmental influences on the health of the Island, and ensuring the maximum potential for positive health gain.

Chapter 4

4.0 Health Promotion

4.1 Introduction

1995 was another very busy year which saw the start of several new projects and the consolidation of others previously set up. We were also delighted to be able to welcome a new member of staff, Mrs Pat Prevel, as Resources Officer. Mrs Prevel joined the Unit in November and has already had a great impact in the library and has enabled us to offer a much more comprehensive resources service. Other developments included;

4.2 Coronary Heart Disease

The Look After Yourself programme continued to go from strength to strength with five basic courses for the general public, three courses for pregnant mothers, three smoking and eight cardiac rehabilitation courses. Although these were all run by independent tutors, the publicity and promotion that the courses needed and the support and advice to tutors, took up a large proportion of the Assistant Health Promotion Officer's time. A new project was the development of a weight management course by the Assistant Health Promotion Officer in conjunction with one of the LAY tutors. The pilot scheme proved to be very successful and it is hoped to run further courses and train the other tutors to teach this course in 1996. The Health Promotion Officers and LAY tutors also took part in C.P.R. and advanced first aid training run by the Ambulance and Rescue Service.

With the support of four members of the Board of Health, January saw the launch of the Flabbusters scheme to encourage participants to lose weight and raise money for their favourite charity. By Easter over 140 Flabbuster packs had been sent out and the Board members had lost over four stone (25 kgs) between them!

Four more establishments were presented with the Heart Beat Award and sessions on coronary heart disease and exercise for Project 2000 nurses, and healthy eating for the Chest and Heart nurses were run.

4.3 Smoking

The smoking programme again centred on No Smoking Day with the theme of "It's Time to Stop". The Assistant Health Promotion Officer organised several training sessions to encourage other professionals to organise their own activities and the Smokebusters Club organised a very successful anti-smoking Poster, Poem or Model competition for school children. In addition, after publicity advertising the fact, a survey of 40 retailers was carried out to see if under 16 year old young people were able to purchase cigarettes. Of the forty premises visited, the under age volunteers were able to buy cigarettes at 16 of them and the results were discussed with the St Peter Port Traders Association.

The Assistant Health Promotion Officer was also instrumental, along with Doctors Boyle and Lee, in setting up an open meeting to encourage parents to work together to stop children from starting smoking.

Support and advice was given throughout the year to the Smokebuster tutors to assist them in their work in schools and a smoking cessation course for young people was run at one of the secondary schools.

Both Health Promotion Officers also attended joint meetings with the Jersey Health Promotion Officers to plan a joint Channel Island smoking strategy. Although discussions are still in the early stages, this looks set to be an exciting development for 1996.

4.4 Cancer

The Assistant Health Promotion Officer ran a very successful series of cancer prevention workshops for workplaces. Ten have been carried out so far and there are plans for more next year.

Materials were again sent out for Sun Awareness Week and publicity given to the need for people to cover up and wear a sunscreen. A skin cancer workshop for professionals and play group leaders was held, as was a session for teenagers at Les Beaucamps School.

4.5 Alcohol and Drugs

A peer-led education training was again held at Les Beaucamps School and 14 Year 10 and Year 11 students then taught their school's Year 7 children all about illegal drugs, alcohol, smoking and saying No. The feedback both from the children and the peer-led students themselves was very positive and it is hoped to continue with Year 8 next year. The Health Promotion Officer continued to attend Drug Concern meetings and also coordinated the production of a leaflet outlining the many different drug education options available to the public, and two drug education sessions were run for groups of secondary school teachers.

4.6 Sexual Health

The Health Promotion Officer assisted in the planning and teaching of two sex education days for primary and secondary school teachers run by the Complementary Health Educators. She also ran a training session for youth leaders on relationships and contraception and a session on HIV and AIDS for Swissville staff.

Two major events on HIV and AIDS were organised in the lead up to World AIDS Day. The first - the Arts for AIDS Awareness Day - consisted of an exhibition of art and creative writing by both adults and young people and included a poetry reading by Poetry in Motion and a lively drama enacted by Studio Theatre. In the evening over 250 people attended a concert by the Guernsey Youth Jazz Orchestra in aid of AIDS charities.

In November fifty women representing a variety of women's organisations attended the "Women, AIDS and the Future Seminar" sponsored jointly by the Health Promotion Unit and the Soroptomists International of Guernsey. It was the first time that many of those who attended had received any AIDS education and many left with a desire to pass on what they had learned. It is hoped to repeat the conference - for women and men - in 1996.

4.7 **Family Health**

The Health Promotion Officer continued to attend and support the Joint Breastfeeding Group and they took part in the Breast Feeding Awareness Week with the theme of Everyone Matters.

4.8 **Accident Prevention**

The Health Promotion Officer also attended a training day in the UK on the "Know Trouble" Accident Prevention Programme. Following this she led two training days for Health Visitors and secondary school teachers on including accident prevention education in their work and a further course for a multi disciplinary group is planned for January.

The Child Accident Prevention Group continued to meet and took part in Child Safety Week and the results of the first year's collection of Child Accident statistics were released.

4.9 **Training**

Nine students, including the Assistant Health Promotion Officer, continued to study for the Certificate in Health Education and this involved the Health Promotion Officer in assessing their teaching practice and supporting them with their research for their projects. All nine completed the course during the year and they were presented with the Certificates by their tutor, Mr Jim Elder, from Northumberland College of Technology in December.

Other training courses led by the Health Promotion Officer included a listening skills course for teachers and a foundation course in Personal, Social and Health Education for school ancillaries.

Training courses attended by the Health Promotion Officers included voice projection, the Jersey Public Health Forum, a Mental Health Promotion Conference, the Annual Certificate in Health Education Tutors' Conference and a Physical Activity Training Day. The Resources Officer also attended the annual Resources and Information Conference in Milton Keynes.

4.10 **Conclusion**

Plans for 1996 include building on the work started in 1995, particularly that of the joint Channel Island smoking initiative and to set up a Child Safety Activity Week for local school children.

It is also hoped that the Unit will move to new premises and that the resources library will be computerised to enable a much more reliable loans and stock control system to be set up.

Figure 5.1

**Report to the Department of Health
Notification of Infectious Diseases 1995**

1995 (Quarters)

	1990	1991	1992	1993	1994	1st	2nd	3rd	4th	Total
Measles	1	2	0	2	1	0	0	1	0	1
*Mumps	0	0	0	0	0	0	0	0	0	0
*Rubella	5	3	0	4	0	0	0	0	4	4
Whooping Cough	3	3	2	0	4	6	0	0	0	6
Food Poisoning	75	47	38	61	13	0	4	1	5	10
Hepatitis A	4	1	0	0	0	0	0	1	0	1
Hepatitis B	0	2	1	2	0	0	0	2	0	2
Meningitis	2	3	1	2	1	1	2	1	0	4
Tuberculosis	1	6	1	2	4	2	2	1	1	6
Malaria	0	0	1	0	0	0	0	0	0	0
AIDS	0	0	0	0	0	0	0	0	0	0
Scarlet Fever	4	3	2	1	1	1	0	0	0	1
Psittacosis	1	0	0	0	0	3	1	1	0	5
Dysentery	0	0	0	2	0	0	0	0	0	0
Other infectious conditions that were reported informally										
Hepatitis C									1	1
Food Poisoning		212	130	187	127	25	30	43	30	128
Carriers of HIV										
antibody	0	0	0	1	5	0	0	0	1	1

* Mumps and Rubella became notifiable in Guernsey on 1 January 1989.

Chapter 5

5.0 Communicable Disease Control

5.1 Overview

Fortunately Infectious Disease Control during 1995 consisted of continued routine surveillance and investigation but without any worrying dramas or exotic diseases.

In numerical terms food poisoning continues to be by far and away the most significant illness. The rates were very similar to the previous few years with laboratory notifications of 128 cases of Salmonella and Campylobacter.

5.2 Reducing Cases of Food Poisoning

A number of the cases of food poisoning began in communal meals in hotels or catering establishments. It has been necessary to continue the message that raw shell egg should not be used for the preparation of foods in the catering industry. Pasteurised egg is an effective and safe alternative that avoids the risk of egg born Salmonella infection which continues to account for a major number of cases. Other poultry born infections are significant and again good food hygiene and preparation practices both in the commercial trade and at home are very important.

There were no major outbreaks of food poisoning, and all cases related to small numbers or were sporadic.

5.3 Communicable Diseases in Children

The common childhood diseases continue to run at very low levels reflecting a successful immunisation programme and good herd immunity. Herd immunity means that when a sizable percentage (exact numbers differ according to the disease) of the population are immune to a disease whether from immunisation or natural infection; this illness becomes rare in the population because the opportunity for transmission are very much reduced. It is through “herd immunity” that killers such as Smallpox have been eradicated.

5.4 Imported Infections

No tropical imported infections were reported. Five reported cases of Psittacosis were higher than usual, but the cases were unconnected and mainly acquired outside the island.

5.5 Preventing a Resurgence of Tuberculosis

We continue to be vigilant regarding Tuberculosis (TB) in view of the reported resurgence of this disease in some deprived areas of the UK, and in the world more generally. Fortunately all the TB cases in Guernsey were either acquired outside the island, or the result of re-activation of previous disease. Whilst there is some resurgence of this illness in deprived areas of the UK, it continues to decline in the areas that are more comparable to Guernsey. Nevertheless, our continued vigilance will be necessary.

Figure 5.2

SEXUALLY TRANSMITTED DISEASES

ANNUAL STATISTICS 1995

DISEASE	MALE	FEMALE	HOMOSEXUAL	TOTAL 1995	TOTAL 1994
Gonorrhoea	4	2	0	6	8
Syphilis	1*	1	1*	2	3
N.S.U./Chlamydia	27	13	0	40	42
Herpes Genitalis	15	12	0	27	23
Yeast	32	45	0	77	69
Hepatitis B	0	0	0	0	2
Hepatitis C	3	0	0	3	1
Human Papilloma	48	31	1	80	81
Pubic Lice/Scabies	16	5	1	22	25
Gardenerella Vaginalis	4	19		23	17
Cervical Smears		25		25	20
Counselling	60	37	8	107	134
HIV Blood Testing	38	20	8	66	114
TOTALS					
New Patients	105	55		160	165
Attendances	273	173		446	565

5.6 Special Treatment Clinic (STC)

The STC continues to provide an important and necessary service for the sexually active in Guernsey. It is committed to further developing a high quality sexual health, promotion and prevention service for this community. The majority of clients who attend seek reassurance regarding their sexual health and confirmation that all is well. This provides an opportunity to promote sexual health and target preventative opportunities such as “safer sex”.

The pattern of disease in Guernsey appears to be little different from that reported from mainland Britain.

Partner notification (or contact tracing) also remains an important part of the work of the STC. It is sometimes more difficult in an island community to provide satisfactory contact tracing without a permanent health advisor, and this is an area that is currently under review.

The majority of patients attend through self referral, but an increasing number are referred by their GP or gynaecologist.

The standard practise for new attendances to the Clinic is a series of screening tests to identify any sexually acquired infection, including blood tests where relevant. The interview includes explanation of the possible infection, the importance of compliance with treatment, and stressing that no sexual intercourse should occur until both the index case and partners have completed treatment, and have had a confirmatory test for cure. HIV prevention can also be discussed.

5.7 HIV/AIDS and Hepatitis C in Guernsey

HIV and AIDS continues to be a major source of extra activity for the Clinic and current HIV positive patients are seen on a regular basis with regular physical examination and blood tests to assess their immune function. There are currently eight patients who have been seen during the course of the year, one female and seven males. There was one death from AIDS in 1995, and of the seven remaining patients, two have subsequently returned to the UK. There were no new cases of infection during 1995. The management of HIV disease is changing with promising results seen with “triple anti viral therapy”. Whilst such new drugs are costly, the benefits in terms of continued well being and continued ability to work are obvious.

An additional area of concern has been the emergence of Hepatitis C amongst a group of young male intravenous drug users, and this is indicative of continuing risk behaviour with sharing of “contaminated needles and syringes”. Many other Hepatitis C patients have been diagnosed by their general practitioners or in prison. Hepatitis C may be regarded as a “marker” for the spread of blood borne infection, and highlights the potential for HIV/AIDS also to be spread in this way unless effective preventative strategies are implemented and maintained.

5.8 Infection Control Committee

During 1995, it was agreed that the Infection Control Committee should extend its advisory function to cover other community based organisations who have a need or interest in infection control, such as St John Ambulance and Rescue Service, Prison Service and other nursing homes, instead of being restricted solely to infection control measures at the Princess Elizabeth Hospital and other Board of Health premises.

This wider brief proved its value during April 1995, when there was an acute virus outbreak amongst elderly patients on two “closed wards” at the Castel Hospital. The viral infection manifested itself with symptoms of fatigue, cough and raised temperature, and led to five deaths amongst elderly patients. The outbreak was later shown to be due to an Influenza B virus.

The infections would have been introduced to the ward by a staff member of the community, either staff or relatives, and illustrates the risks of spread of infection amongst debilitated patients in a “closed community”. Staff members on these wards are now offered influenza immunisation at the start of the winter in an attempt to reduce risks of introduction of infection to such the wards. Experience gained during this outbreak proved valuable in outbreak control measures implemented in further hospital based respiratory tract outbreaks later in the year.

5.9 Infection Control and the Community

An outbreak of acute gastro intestinal infection believed to be due to a “Small Round Structured Virus” (SRSV) infection forced the closure of one Junior school in June 1995.

These infection control measures proved effective, and there was no widespread extension into the community. A similar increase of SRSV infections has been noted in England, where there has been a tenfold increase in laboratory confirmations between 1990 and 1995.

An epidemic of “flu like illness” affected several hundred local residents towards the end of November 1995. There was good cooperation and sharing of information between Family Practitioners, the Consultant Pathologist, and public health personnel. Despite appropriate viral studies being taken, no definitive organisms were isolated.

Chapter 6

6.0 Occupational Health

6.1 Benefits of improved occupational health

All employees have a right to expect a safe and healthy working environment, and safe conditions of employment.

These expectations have been developed and codified by Health and Safety legislation in the UK, and more recently by a number of European Community Directives.

Similar developments have occurred in Guernsey, particularly since the passage of the Health and Safety at Work Law (Guernsey) 1987, and the establishment of the Health and Safety Executive.

However, the States policy of “manpower capping” presents an additional challenge in Guernsey, because generally it is not easy to replace an employee suffering work related illness or injury. Reducing avoidable injury or sickness absence therefore effectively increases the size of the capped public sector workforce.

The Board of Health is the largest employer amongst States Committees, with 1400 Full Time Equivalent (FTE) staff. Many of these have specialist nursing or other technical skills, and could not be easily replaced in any case.

6.2 Establishing an Occupational Health Service

The Board of Health therefore accepts that it has particular benefits to gain from a reduction in unnecessary work related injury or absence, and has agreed to support the further development of an Occupational Health Service for all Board of Health staff.

A qualified Occupational Health Nurse was recruited during 1995, and will be assisted by a part time Occupational Health Medical Officer. The new Unit will be established on the Princess Elizabeth Hospital site, and objectives will include;

- Promoting health awareness within the workforce.
- Providing a quality Occupational Health Service to all Board of Health employees.
- Ensuring that impartial and objective advice on occupational health related matters is available to both employer and employee.
- Ensuring that health surveillance is undertaken where appropriate, in accordance with statutory or accepted responsibilities.

6.3 Achieving Better health in the Workplace

To achieve these objectives, the Occupational Health Service will;

- Ensure that the Service complies with all criteria demanded by the Kings Fund Organisational Audit due to be conducted during October 1996.
- Introduce an occupational health computer database to allow the storage of work related health information under secure and confidential conditions.
- Monitor sickness absence and provide appropriate health advice to line managers and staff.
- Ensure that all staff at risk of blood borne diseases are offered appropriate protection by immunisation.
- Conduct pre-employment screening to ensure that all staff are physically and mentally fit for their allocated duties.
- Provide ongoing health surveillance in the workplace to ensure an individual's continuing fitness to perform assigned duties.
- Advise on work related illness and injuries, early retirement on medical grounds etc.
- Work with the Health Promotion Unit to promote health education programmes for Board of Health employees covering such topics as protective equipment, smoking cessation, healthy eating, promoting exercise and other related matters.
- Participate in occupational health research relevant to the needs of Guernsey.

It is hoped that such a range of measures will contribute to a quantifiable fall in unnecessary work-related illness and injury, thus maximising the effectiveness of the Board of Health's workforce within the manpower cap.

Proven success may lead to the extension of an enhanced Occupational Health Service to benefit the staff of other States Committees.

Chapter 7

7.0 The Health of Guernsey Children

7.1 “The health of our children”

In November 1995, the Office of Population Censuses and Surveys (OPCS) published a Decennial Supplement “The health of our children”. This volume brings together a wide range of health statistics, with comments from a number of expert contributors in order to present “*an overview of the health of our children*”.

The volume points out;

- “*Infant mortality has traditionally been a major measure of the health of a nation. In developed countries, however, mortality levels are at an all time low. It is therefore time to consider levels of morbidity in childhood, their causes (if known) and associated health costs.....*”.
- “*There is abundant evidence that the quality of children’s health is threatened by a multitude of new problems of many different types, the pervasive effects of adverse demographic, economic, and cultural developments and changes in priorities.....*”.
- “*There has been an overall increase in childhood adverse behaviour, with high levels of tobacco, alcohol, drug and volatile substance misuse, and early sexual activity, and evidence of poor diets, falls in physical activity and increases in obesity. New studies on the mental health of children have revealed high levels of disabling behaviour and psychiatric problems.....*”.

7.2 Relevance for Guernsey

As pointed out in Chapter 1, last year’s Annual MOH Report for the first time explored a “health theme” in somewhat greater depth. The theme chosen then was “Marriage and Family in Guernsey - an analysis of social trends 1964-1994”.

It has also been mentioned (Chapter 2) that the Board of Health has determined on a more strategic approach to service planning, with the establishment of Service Planning Teams. One of the groups so established was the Maternal and Child Health Services Planning Team.

Within the fields of Maternal and Child Health Services, the team was given a brief to;

- Collect information on current services.
- Identify strategic objectives for the service.
- Identify deficiencies in present services.
- Recommend areas for service development/improvement.
- Develop priorities for such developments/improvements.

Figure 7.3.1 Live birth rates per Thousand Population
Guernsey and England/Wales
1961-1995

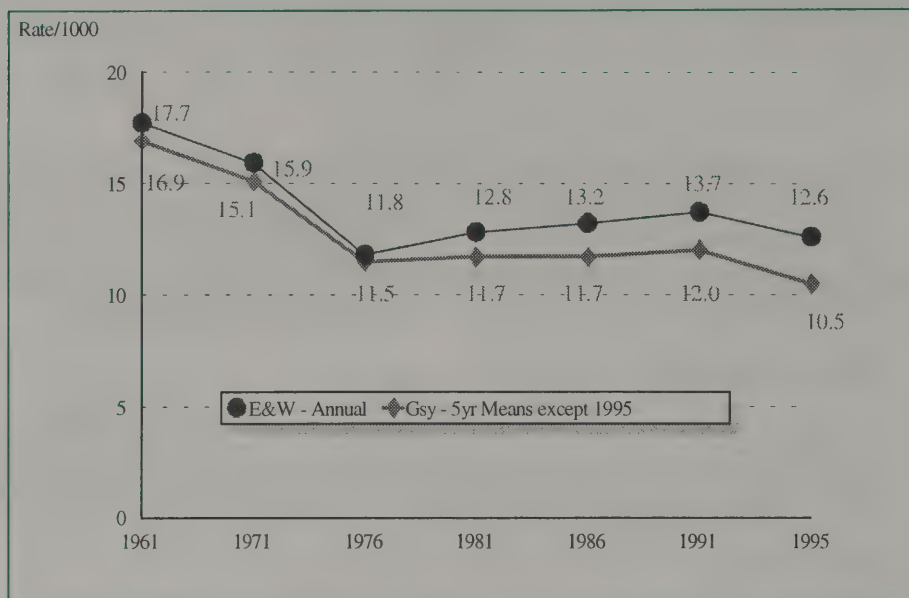
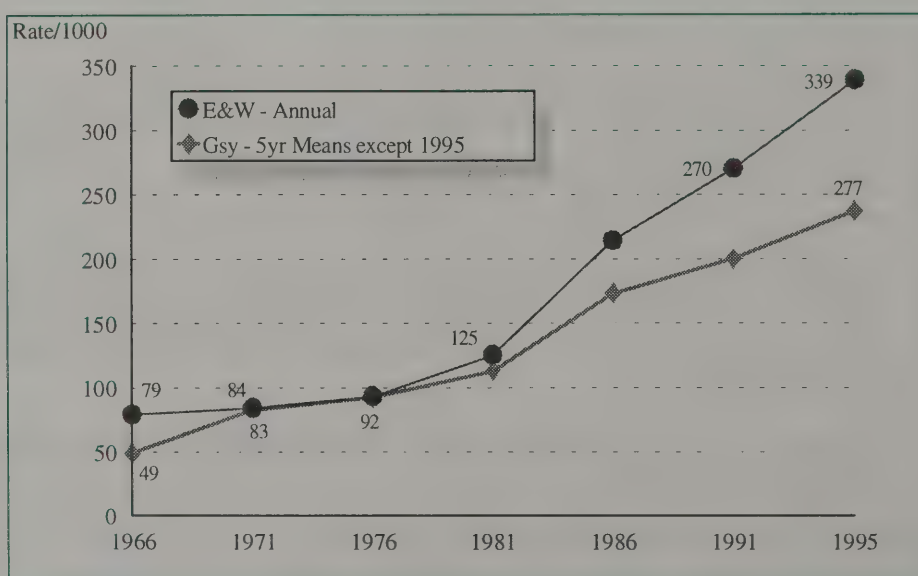


Figure 7.3.2 Births Outside Marriage
[Rates per Thousand Live Births]
Guernsey and England/Wales
1966-1995 compared



Sources: Population Trends 80 OPCS 1995
States of Guernsey Greffe 1995

7.3 The changing context of childhood

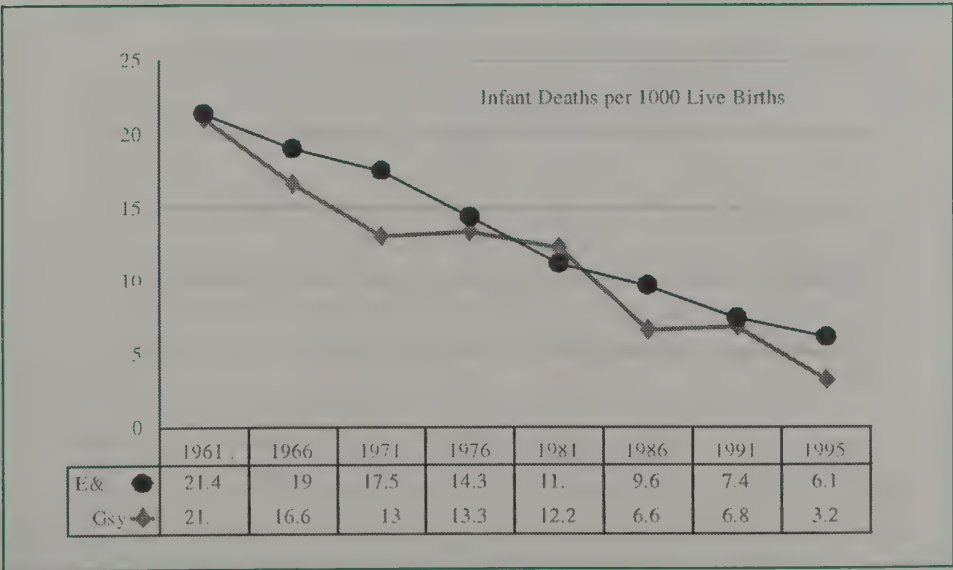
It therefore seemed relevant to extend the theme of “Marriage and Family in Guernsey” onto “The Health of Guernsey Children”, and to build on the work of the Maternal and Child Health Services Planning Team in order to compare changing patterns of health, health risk factors and health related behaviour of children in Guernsey over the past three decades with that of their counterparts in Britain, as summarised in “The health of our children”.

The section on “Marriage and Family in Guernsey” in the 96th Annual MOH Report concluded;

- “On an annual basis, fewer people are choosing to marry (although some may cohabit), women are choosing to work in preference to starting a family, they are choosing to have fewer children, and have them later in life than ever before.”
- “Although there are fewer babies born on the Island, they are generally healthier, with fewer of lower birth weight, fewer still births, and fewer infant deaths than ever before.”
- “Unfortunately more children will experience a divorce in their family, and it is also likely that an increasing number will be exposed to second subsequent marriages.....”

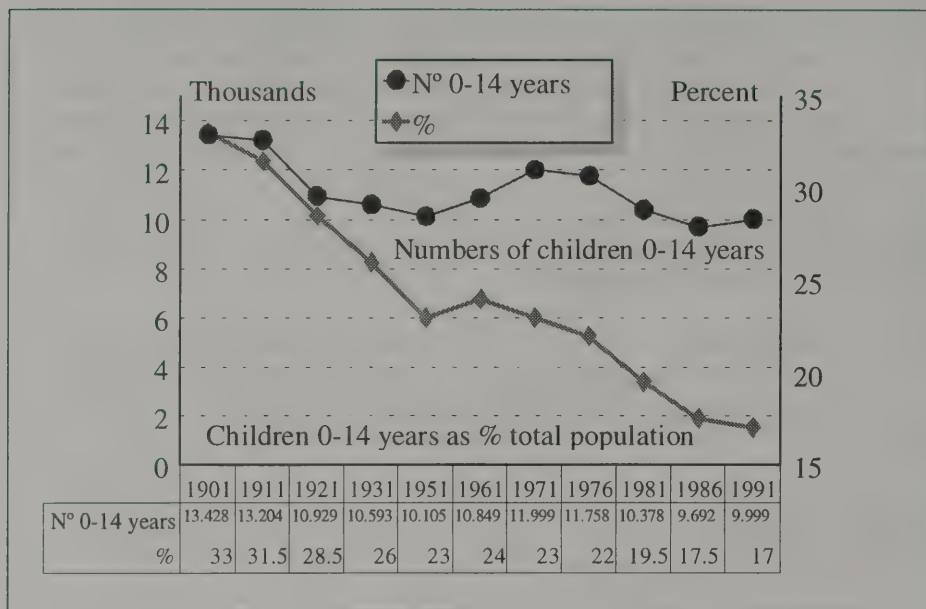
Some of these changes are summarised in Figures 7.3.1-7.3.3.

Figure 7.3.3 Infant Deaths per Thousand Live Births
Guernsey and England/Wales
1961 - 1995 compared



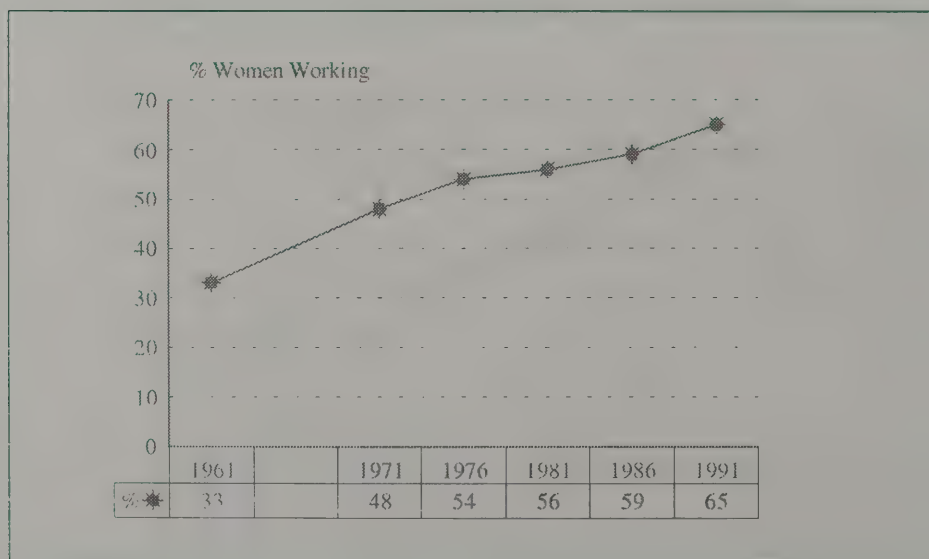
Sources: Population Trends 80 OPCS 1995
States of Guernsey Greffe 1995

Figure 7.4.1 Child Population 0-14 years - Census Totals
and as Percentage of Total Population
Guernsey 1901-1991



Source: Guernsey Census 1901-1991

Figure 7.4.2 Working Women as % of
Total Female Population 15-65
Guernsey 1961-1991



Source: Guernsey Census 1901-1991

7.4 Trends in Childbirth and Family in Guernsey

Marriage and divorce rates have remained similar in 1995 to 1994, although below the five year mean for 1989-1993. Divorces as a percentage of marriages remained constant at 44%.

However, both the crude birth rate (number of births per 1,000 population) and the natural fertility rate (number of births to women aged 15-44 years) have shown a further fall, and are presently the lowest on record in post war years. Similarly, births outside marriage have also increased, and now comprise 27.7% of all births, the highest on record.

One consequence of falling fertility accompanied by falling childhood mortality is there are not significantly fewer children in the Guernsey population than 30 years ago, although the overall proportion has fallen from 24% to 17% over this period [Figure 7.4.1].

Similar trends have been noted in Britain, where “The health of our children” comments *“The size of the population of children has changed little despite the large fall in fertility rates between the mid 1960’s and the mid 1970’s. This is a direct result of falling mortality rates for children.”*

In trying to explain this falling fertility, the rise in the number of working women is obviously relevant. In 1961, only 33% of women aged 15-65 years in Guernsey were described as being “economically active”. By 1991, this had increased to 65% of all women in this age group [Figure 7.4.2]. During this period, the proportion of women in the workforce increased from 33.8% of the working population in 1961, to 43.2% in 1991. Women in Guernsey are choosing to work in preference to starting a family.

“The health of our children” notes similar trends in Britain, and comments *“Fertility rates were also related to the rise in real house prices during the 1970’s and mid 1980’s. it is calculated that a 14% increase in women’s earnings in relation to men’s, and a 60% rise in real house prices both reduce family size by about 12%”.*

“The low levels of fertility are primarily due to women having fewer children..... There is a large literature on the effects of family size, children from large families are less likely to stay on at school beyond the statutory leaving age, have lower educational attainment and are smaller in physical size. These differences are substantial.”

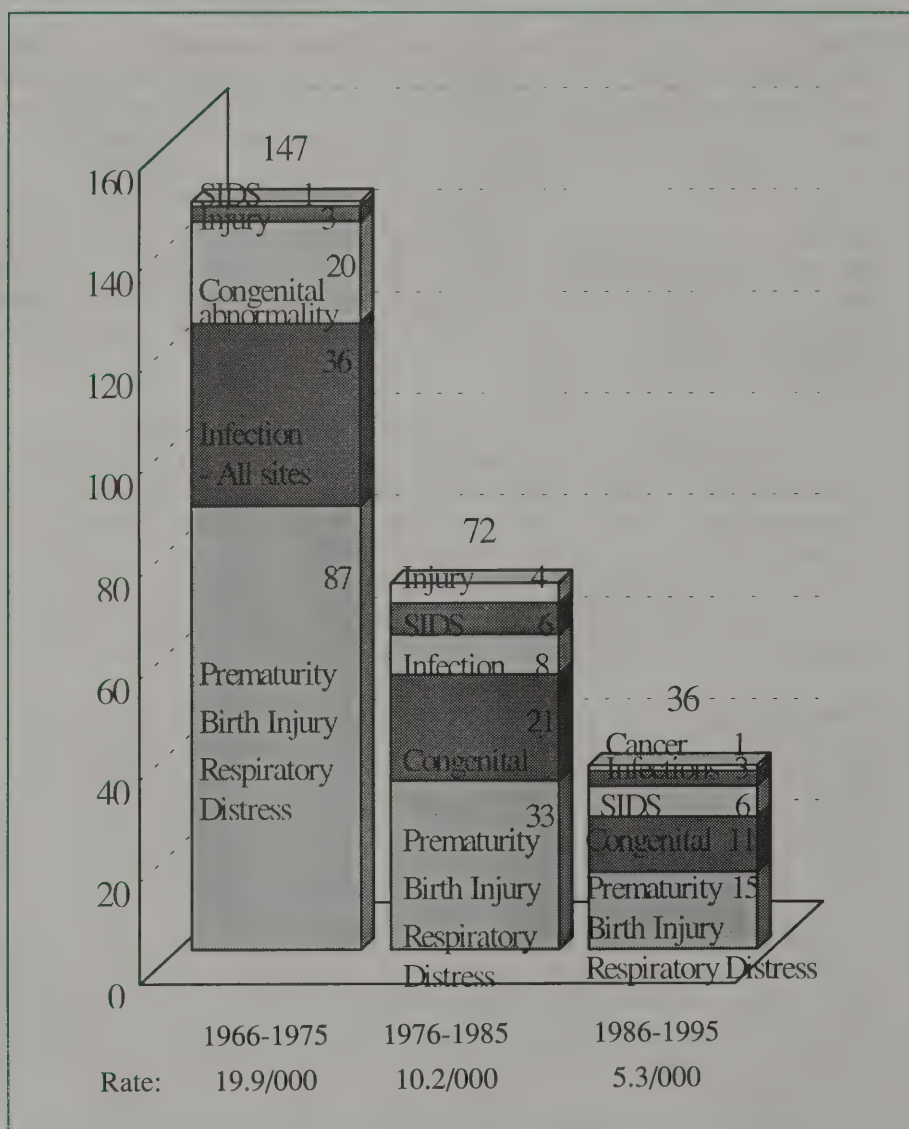
“The health of our children” concludes;

“By comparison with early decades, children are now much more likely to be born into a family where their mother is in employment (often part time). They are also more likely to experience living with only one biological parent at some time.”

On the evidence available, similar changes are being experienced by children in Guernsey.

Figure 7.5

Deaths Less than One year by decade Guernsey 1966-1995



Source:

Guernsey MOH Annual Reports 1966-1995

7.5 Health in the first year of life

● Patterns of Infant Death

Infant deaths refer to all deaths of live born babies before their first birthday. International comparisons have shown that the infant death rate (infant deaths per 1,000 livebirths) are a good proxy for overall health, welfare and social provision for a mother and her child. In Guernsey, the steady fall in the infant death rate of the last 35 years continued into 1995 [Figure 7.3.3]. However, it is not just the falling numbers, but the changing pattern of infant death over the past three decades which is of interest and importance. Because of the small number of infant deaths in any one year, ten year totals around Census years have been taken. These show a fall from 147 infant deaths between 1966-1975 (a rate of 19.9 per 1,000 livebirths) to 36 infant deaths between 1986-1995 (a rate of 5.3 per 1,000 livebirths) [Figure 7.5.1]. The major contributions to this fall have been in the reduction in adverse factors around the perinatal period (prematurity, birth injury, respiratory distress) where there has been a fall from 87 deaths between 1966-1975 to 15 deaths between 1986-1995.

There has been an equally dramatic fall in deaths said to be due to infection, with a fall from 36 deaths between 1966 and 1975, 8 between 1976 and 1985, and only 3 between 1986 and 1995.

The fall in deaths from congenital abnormality has been less marked, from 20 in 1966-1975 to 11 in 1986-1995, but this is a field in which recent improvements in antenatal diagnosis with abortion being offered in cases of severe congenital abnormality or hereditary pathology can do much to further reduce deaths from these causes. The fall in injury deaths shows greater awareness amongst parents and healthcare workers of this important cause of childhood morbidity and mortality.

The changes in Sudden Infant Death Syndrom (SIDS) is also of interest. SIDS only received an ICD (International Classification of Disease) coding in 1968, and during the period 1966-1975, it is likely that the syndrome was under diagnosed. "Cot deaths" may have been ascribed to infection or other causes. There appears to have been little fall between 1976-1985 and 1986-1995, but a recent better understanding of the cause of SIDS should result in a decline of deaths from this cause in future decades.

7.6 Further Improving Infant Health

The death of a wanted baby during the first year of life is always a tragedy, and further improving infant health and preventing avoidable infant deaths in Guernsey will require;

- maintaining the quality of obstetric and perinatal services,
- improved diagnosis and prevention of congenital abnormalities,
- reducing maternal smoking during pregnancy (which has been shown to be associated with smaller babies and adverse perinatal outcomes),
- reducing parental smoking during infancy (associated with increased infections and increased rate of SIDS),

- promoting breast feeding (associated with reduced infection, and reduced hospital admissions etc),
- maintaining high immunisation levels.
- fostering improved communication amongst health professionals, and with other agencies.

7.7 Improving Breast Feeding Rates

Respiratory and diarrhoeal illness are currently the commonest cause of admission of infants less than one year to the Princess Elizabeth Hospital. It has been shown the rate of hospital admission for bottle fed babies is just over five times greater than in babies who have been breast fed for 13 weeks or more. Each 1% increase in breast feeding would save the NHS in England and Wales about £1/2 million annually in reduced hospital admission costs. Successful breast feeding also benefits the development of mother/child relationships. In 1992, breast feeding rates at birth were found to be 59% in Guernsey, 65% in South West England, compared with 74% in London/South East England.

Not only were breast feeding rates lower, but Guernsey mothers tended to stop sooner. For example, at six weeks only 32% of the Guernsey mothers were still breast feeding, compared with 39% of breast feeding mothers in the UK as a whole.

“Health for Guernsey People” suggested a number of strategies for improving breast feeding rates in Guernsey, foremost of which was a joint Guernsey Breast Feeding Group to involve midwives, health visitors, paediatricians etc.

Since the formation of such a group and the adoption of a more strategic approach to encouraging breast feeding, there has been a steady improvement in breast feeding rates as follows;

Year	Breast feeding rates			
	At Birth discharge	Hospital discharge	Midwife	28 days
1992	60%	52%	44%	45%
1993	63%	57%	53%	46%
1994	70%	63%	56%	49%
1995	71%	66%	61%	55%

Source: Ann Lomax, Health Visitor, Community Services, Guernsey

It can be seen that relatively simple measures such as better communication, improved co-ordination, and working across a range of sectors to promote breast feeding has achieved substantial improvement in the numbers of women breast feeding at birth. Unfortunately, there is a substantial drop off over the first month of life, and therefore many babies are not getting the full benefits of breast feeding, at a time when they are most vulnerable to infection, and therefore have most to gain from breast milk.

Increasing and maintaining local breast feeding rates remains an ongoing challenge for all concerned with further improving infant health in Guernsey.

7.8 Reducing Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS or “Cot Death”) was until recently regarded as *“the largest single cause of infant death between 1 month and 1 year of age”*.

It was also known as the *“disease of theories”*, with genetic, perinatal events, infection and environmental influences all having been suggested as contributing to a “final common pathway” leading to infant death. Locally there has been interest and speculation in whether plastic mattress coverings might be implicated.

However, research has now led to a better understanding of the condition, and countries which have promoted a similar range of measures have experienced a measurable fall in SIDS. Deaths from SIDS fell by two thirds in England and Wales between 1989 and 1993 following the “Back to Sleep” Health Education Campaign (started in 1991). Similar campaigns conducted in Australia, New Zealand and several other countries led to a decrease in SIDS of 50% or more.

Parental smoking is also felt to be a major contributing factor to SIDS, now accounting for over 60% of all cases.

As yet, it has not been possible to demonstrate a similar fall in SIDS in Guernsey. However, consistent health advice from paediatricians, family practitioners, health visitors and other child health nurses will undoubtedly contribute to this in future years. Such advice should stress the importance of;

- placing the baby on the back to sleep.
- Quitting smoking during pregnancy.
- Avoiding smoking in the same room as the baby.
- Avoiding letting the baby get too hot.
- Placing the baby in feet to foot of cot position.
- Seeking advice promptly if the baby is unwell.

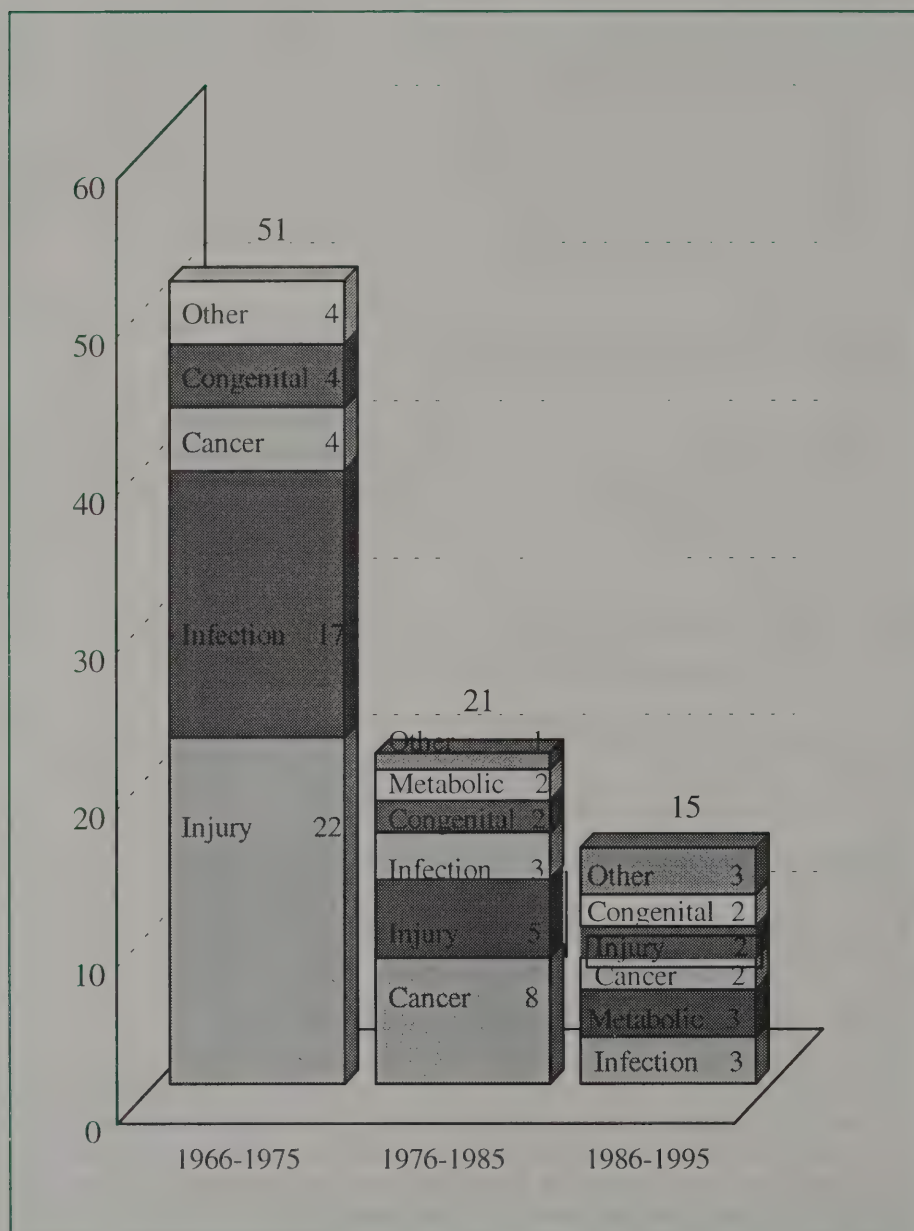
7.9 Improved Communication and Infant Health

Fostering improved communication amongst health professionals has been identified as an important strategy for ensuring better health in early childhood. A range of health professionals and health services may be involved in the health of the pre-school child. These may include the hospital childrens ward, and Accident and Emergency Department, Paediatrician, Family Practitioner, Health Visitor, and the specialised services at Bell House.

Communication between the various service providers is essential, and Guernsey was ahead of many parts of Britain in introducing a Parent Held Child Health Record [PHR] in 1993.

Figure 7.11

Deaths 1-14 years by decade Guernsey 1966-1995



Source:

Guernsey MOH Annual Reports 1966-1995

The concept of the parent held personal health record is simple. A passport sized booklet in a durable plastic cover is given to the parents of all newly born babies in Guernsey. Its intended functions are;

- To document the major health events in a child's life eg immunisation.
- To improve communication between health professionals involved in the child's care.
- To increase the parents sense of involvement with and responsibility for their child's health.
- To provide an easily accessible reference for child health and medical emergencies.

The use of personal health records in developing and industrialised countries has been endorsed by the World Health Organisation and by UNICEF. An evaluation on the Guernsey PHR in 1993 showed that the vast majority of parents and health professionals welcomed and used the PHR. The "green book" is rapidly becoming part of our health culture.

7.10 The Community Child Health Computer System

A further development during 1995 was the introduction of the Community Child Health Computer System. Introducing this required much preliminary work including entry of existing data, and staff training. Data on childrens' immunisation, and associated payments to Family Practitioners will shortly be fully computerised. Developmental surveillance data is also being recorded, thus offering the ability to audit these services for the first time. During 1997, data collected by the school health surveillance system will also be recorded, together with audiological data, and the establishment of a special needs register.

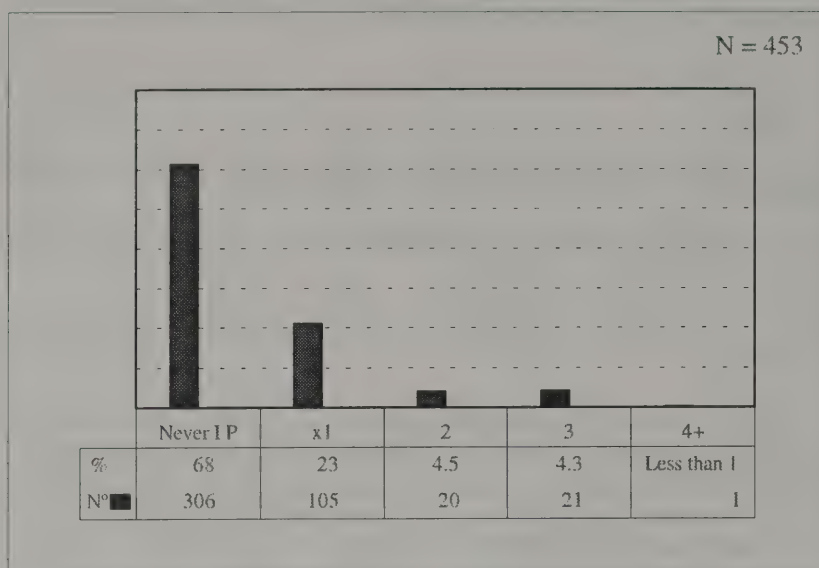
7.11 Childhood Mortality after Infancy

The dramatic changes in infant mortality over the past 30 years are paralleled by equally impressive reductions in deaths from all causes in children aged 1-14 years. Again due to small numbers, deaths from all causes are shown by decade around Census year populations. Again however the proviso regarding the interpretation of small numbers must stand.

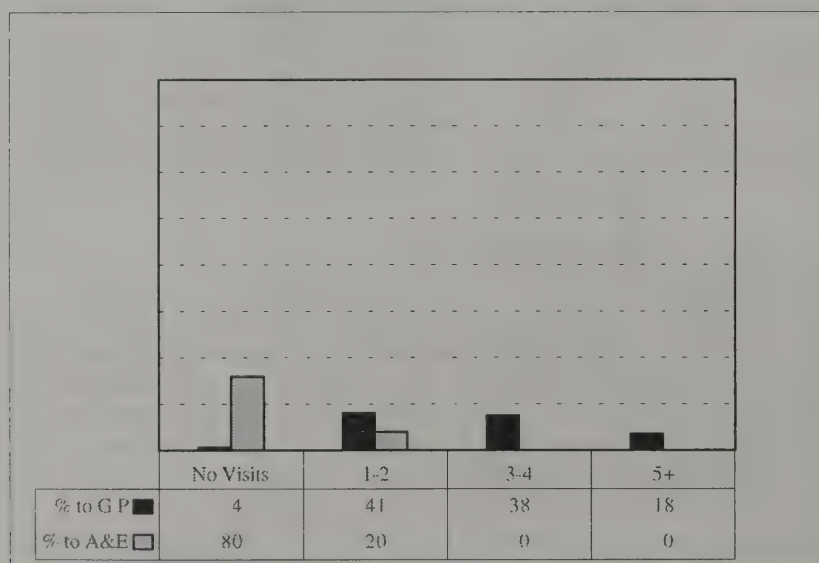
It would appear that deaths from all causes have declined from a mean of 5.1 per annum (a rate of 49 per 100,000 child population aged 1-14 years per annum) between 1966-1975 to a mean of 1.5 deaths (a rate of 15.6 per 100,000 child population aged 1-14 years per annum) between 1986-1995.

Again the pattern of childhood deaths is instructive, with a fall in injury deaths from 22 in 1966-1975 to 5 in 1976-1985 and 2 between 1986-1995. Infection also has fallen from 17 to 3 to 2 per decade over this period, and childhood cancer deaths have halved from 4 to 2 during this time.

**Figure 7.12.1 Total Reported In-Patient [I P] Admissions
Guernsey Children aged 5 years - 1996**



**Figure 7.12.2 Reported Annual frequency of
G P and A & E Attendances
Guernsey Children aged 5 years - 1996**



Source: Guernsey School Entry Survey 95/96

7.12 Health in the pre-school years - The Guernsey School Entry Survey

As part of the school entry process, all children are offered a school entry medical by the School Health Service - Medical Officer and School Nurse.

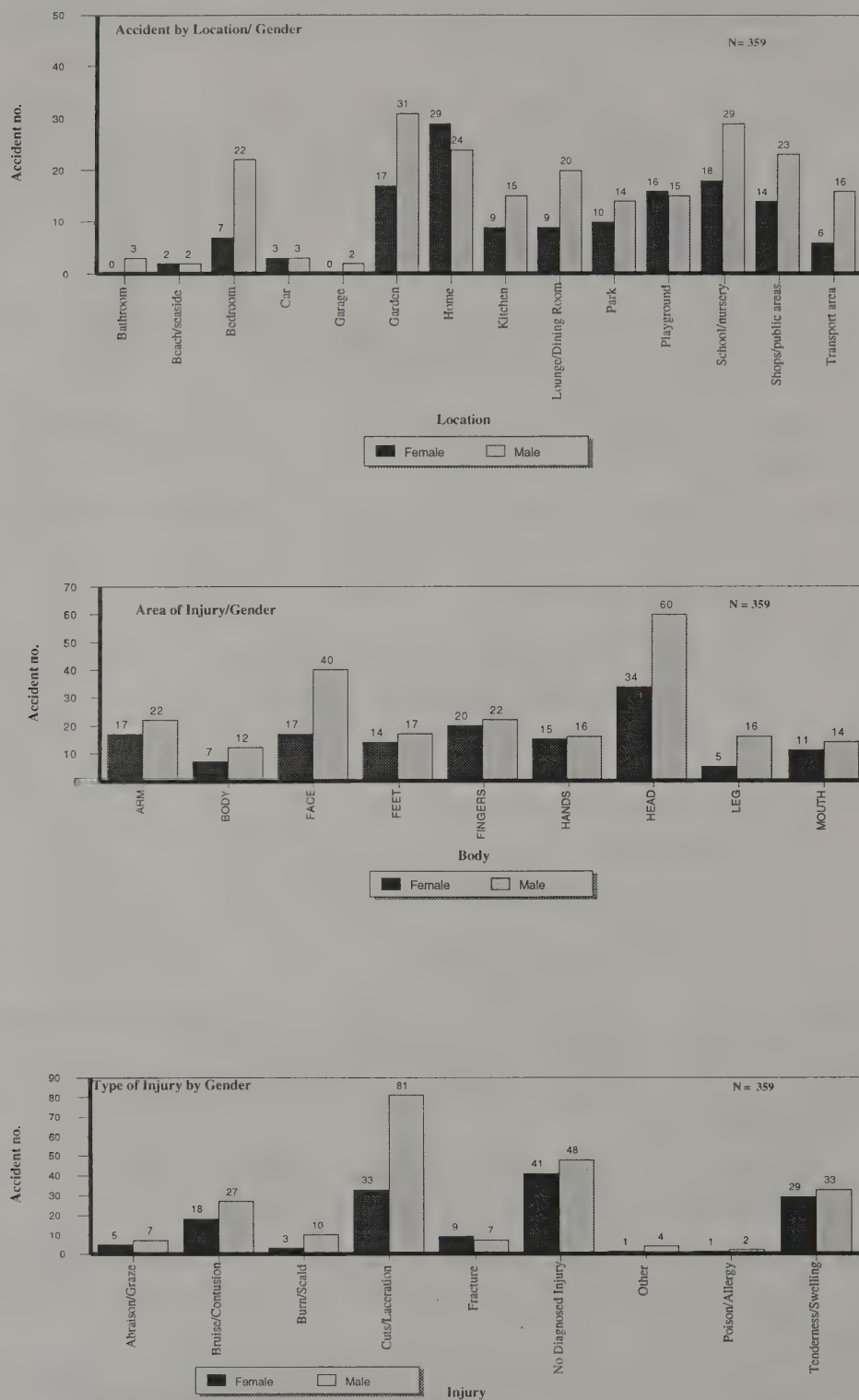
For the first time during 1995/96, a Utilisation Review/Satisfaction Survey of all health services during the first five years of life was performed. Parents were requested to fill in a simple 10 part questionnaire asking which health services they had used, the reasons for this, their satisfaction with the service, and any suggestions for improvements.

In all 453 completed forms were returned (60% of the school entry population of 755 children). Although the results have not yet been fully analysed, it is interesting to note;

- 68% of the children surveyed had never been admitted as a hospital in-patient.
- Amongst the children who had been admitted (total 149 admissions), the most common causes were
 - ENT surgery 28 (19%)
 - Other surgery 23 (15%)
 - Respiratory infections 18 (12%)
 - Other infections (except GI) 15 (10%)
 - Accidents 14 (10%)
 - Asthma 12 (8%)
 - Other stated conditions 12 (8%)
 - GI infections 10 (7%)
 - Admitted for investigations 5 (3%)
 - Allergies 3 (2%)
 - No reason stated 13 (10%)
- The pattern of childhood admissions as recalled by parents does not exactly mirror the records on Childrens Ward.
- Additionally, some 92 children are said to have attended the A&E Department.
- Pre-school children were generally said to attend the Family Practitioner 1-4 times annually [Figure 7.12.2] .
- Over 13% of children claim to have had no contact with a health visitor during the first four years of life - some of these may have been born outside Guernsey.
- The most frequent suggestion for improvement in child health services was for “doctors to take more time - to listen more”.
- Several mothers suggested the need for more continuity and easier contact with their health visitor.

Many respondents claimed to be unaware of the facilities at Bell House which was opened in 1994. Further publicity of the services offered may be worthwhile.

Princess Elizabeth Hospital/St John Ambulance & Rescue Service Child Injury Surveillance. January - June 1996



Source: PEH/SJA Accident & Emergency Dept.

Figure 7.13

7.13 Some Important Child Health Issues

● Accidents

“The health of our children” states *“Unintentional injuries or accidents are the commonest cause of death and hospital admission in children aged 5-16 years in the UK”*.

It further estimates that the direct cost to the NHS of accidental injury in childhood are over £200,000,000 per annum. It points out that although there have been reductions in child accident mortality rates in England and Wales over the last 20 years (from 12.1 per 100,000 child population between 1975-1979 to 7.3 per 100,000 child population between 1989-1991) hospital admission rates for child accidents continue to rise. For example in one recent UK study, admissions for all accidents and trauma increased by 42% from 117 per 10,000 population in 1986 to 166 per 10,000 population in 1990.

The analysis of Guernsey childhood deaths post infancy given above shows a major decline in childhood injury deaths in Guernsey between 1966-1975 (22 deaths) and 1986-1995 (2 deaths).

However, the 1995/96 School Entry Health Survey shows that treatment of injury was still a major cause for non elective admission to hospital during the first five years of life, but unfortunately there is no longitudinal data to show trends.

“The health of our children” comments *“Injuries are not accidental, but occur predictably when an interaction of host, agent and environment occurs. The complexity of these interactions means that simple categorisation of cause will not always provide the full picture: knowledge of how factors interact with each other to produce or avoid injury events is needed.”* In order to get this greater detail of how child injuries occur in Guernsey, a child injury surveillance system was established in the Accident and Emergency Department at the Princess Elizabeth Hospital in 1994/95.

The Survey relies on parents being given a simple questionnaire to complete when a child attends the A&E Department with an injury or poisoning, for the parents to actually complete and return the form, and for the doctor or nursing staff to complete details of the treatment given.

Breakdown in this sequence can result in inadequate data collection, and an incomplete picture of the types, location and causes of childhood injuries in Guernsey.

The situation is further complicated in Guernsey in that the St John Ambulance and Rescue Service also run a treatment room, where many parents will take an injured child in the first instance. Data collection from St John Ambulance and Rescue Service using an identical questionnaire to that used in the Princess Elizabeth Hospital A&E Department commenced in January 1995.

The appointment of a Public Health Data Collection Clerk in January 1996 has led to some improvement in completion rates, and an analysis of the first six months collection are shown in Figure 7.13.

Figure 7.14.1 “Breathing Difficulties”
Guernsey Children Aged 13-14 years
1995/96

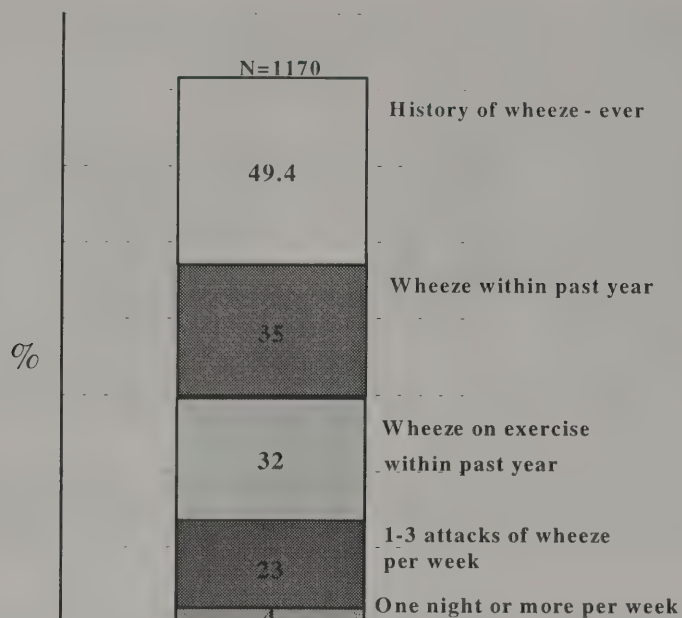
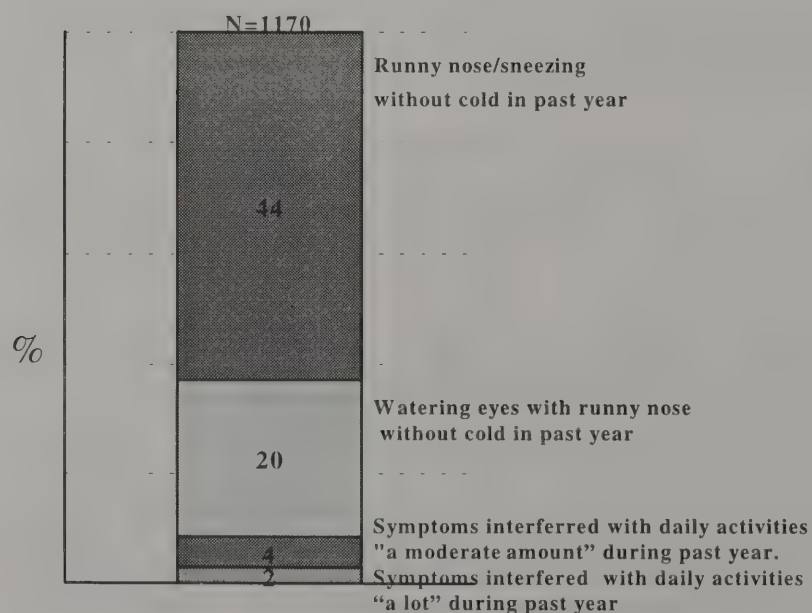


Figure 7.14.2 Upper Respiratory Tract Allergic Symptoms
Guernsey Children Aged 13-14 years
1995/96



7.14 Respiratory Disease in Childhood

The school entry health survey showed that disease of the respiratory tract is the most common cause for both elective and emergency admission to the Princess Elizabeth Hospital.

Amongst the most common causes of non-elective (emergency) admissions to the Princess Elizabeth Hospital is asthma.

Asthma is defined as *“an abnormal response of the airways to a wide range of environmental factors which results in episodes of obstruction to airflow manifested by wheezy shortness of breath”*.

With regard to childhood asthma in Britain, “The health of our children” comments;

- Asthma is the most important chronic disease in childhood.
 - Anti asthmatic drugs are the most commonly prescribed drugs in childhood.
 - There has been a 1300% increase in admissions for asthma in the 0-4 year age group, and a 600% increase in the 5-14 year age group between 1962 and 1985.
 - Similar increases have occurred in most other developed countries.
- The reasons for this are not clear, but may include;
- Changes in house design - more fitted carpets, central heating, double glazing etc.
 - Changes in external environment such as industrial pollution, car exhaust fumes.
 - Changes in children’s lifestyle - more TV/computers, fewer informal outdoor activities.
 - Increased awareness of asthma as a diagnosis by health professionals.
 - Increased preference for admission to hospital by parents and health providers.

● ISAAC

There is a perception that asthma and other allergic conditions may be more common in Guernsey than amongst similar populations in the South of England.

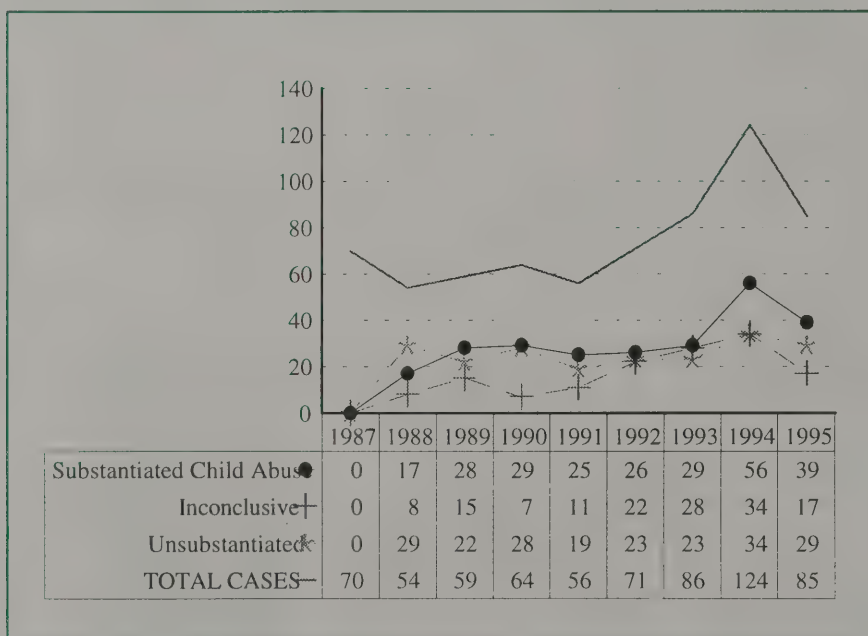
To test this hypothesis, Guernsey participated in ISAAC - “the International Study of Asthma and Allergy in Childhood”. This international study involved a self completed questionnaire which asked about breathing, skin and nasal symptoms and home conditions amongst children in Years 8 and Years 9 (13-15 year olds), under supervision in a school setting.

The UK arm of the study involved one school being selected at random from every county in England, and from every region in Scotland and Wales. All secondary schools in Guernsey agreed to participate, and the study was also performed amongst most secondary schools in Jersey and the Isle of Man.

Similar studies were also carried out in North America, Latin America, Africa, Hong Kong, Australia, New Zealand, India and a number of European countries.

Figure 7.15

**Guernsey Child Protection Committee - Child Protection Investigations
Guernsey 1990-1995**



Source: Guernsey Child Protection Committee Annual Reports 1990-1995

A full analysis and comparison of the results will take several years to complete, but a preliminary analysis for Guernsey has now been completed. This suggests;

- That wheezing and upper airways allergy (“runny nose/itchy eyes”) are roughly similar in Jersey and Guernsey.
- Rates of wheezing in Guernsey are consistently above the average for England as a whole, but somewhat less than the worst affected parts of the UK (mainly Scotland and Northern England).
- Levels of upper airways allergy (“runny nose/itchy eyes”) are roughly similar to the UK as a whole.
- Skin allergy does not seem a major problem in Guernsey.

The full analysis and international comparisons will make a fascinating study, and provoke questions as to what action needs to be taken to reduce this important cause of childhood morbidity.

7.15 Child Abuse and Neglect

It would not be possible to leave the subject of child health without giving mention to the growing problem of child abuse and neglect.

“The health of our children” comments *“Unfortunately there is a minority of children who suffer at the hands of those who are supposed to care for them”*.

Child Protection Registers kept by local authorities in England record the number of children in whom there is proven abuse (neglect, physical, sexual, emotional and grave concern). Over one third of children are included in the register because of “grave concern” where abuse or neglect is suspected.

National data has been compiled from these registers since 1989 and show a wide year to year variation from 41,200 in 1989 to 45,300 in 1991 down to 32,500 in 1993 and increasing slightly to 34,900 in 1994. It is difficult to be certain of how accurately such registers record the true level of child abuse in the community, and how much they reflect the concerns of society, and the resources available to investigate them.

In Guernsey, the number of cases investigated show a similar wide year to year variation from a low in 1991 of 56 cases investigated (23 substantiated), to a high of 124 cases investigated (56 substantiated) in 1994 [Figure 7.15]. Although there is considerable year to year variation, the overall trend over the past eight years is undoubtedly upwards, although once again it is difficult to be sure whether this increase is genuine, or perhaps due to increased awareness and identification of cases. The overall incidence of proven child abuse cases appears to be similar to parts of the UK such as South West Dorset.

7.16 Health and the School Aged Child

The impressive gains in infant health, and improving health indices in the pre school years have already been mentioned.

These improvements in health status continue during the school years.

Numbers of admissions of school age children to hospital in Guernsey tend to be too low for any formal analysis. However, figures from the Hospital Episode Statistics for England for year ending 31 March 1994 show a hospital admission rate for the 5-9 and 10-14 year age groups to be approximately one quarter of those amongst the 0-4 year age group.

The same statistics show that the amongst the 371,000 children aged 5-14 years admitted to hospital in England during this period, the most common reasons for admission were;

- Diseases of the respiratory system (predominantly asthma) 84,000 (23%)
- Injury and poisoning (all causes) 77,000 (21%)
- Diseases of the nervous system and sense organs (including ENT surgery) 63,000 (17%)
- Diseases of the digestive system 61,000 (16%)
- Diseases of the genito urinary system 27,000 (7%)
- Neoplasms (cancer) 19,000 (5%)
- Mental disorders 14,000 (4%)

It is likely that a similar proportion would be found amongst the school aged children admitted to hospital in Guernsey.

7.17 School Health Services

The foundations for the Schools Medical Service date to the early years of this century, when the special skills required by Health Visitors and School Nurses were recognised by a special examination first introduced in England in 1908.

The first formal “inspection” of children at school in Guernsey was also in 1908, although it was 1927 before the first school nurses were appointed.

Initially, the concept was of a “medical inspection service” for the early detection of disease and other potentially remedial defects which might affect educational attainment.

Over time, this was refined into concepts such as “health surveillance” and formal “screening” for disease.

The changing and generally improving pattern of physical health in childhood has led to periodic calls for reappraisal of child health services, leading to the establishment of a working party amongst leading child health professional associations.

The working party, under the chairmanship of Professor David Hall published “Health for all children” in 1989. Having examined the evidence, the working party recommended a reduction in the number of screening tests and procedures, rejecting those for which no scientific justification could be found.

In their place, the working party recommended a greater commitment to health promotion, and to increasing the role of parents in the prevention of ill health and the promotion of good health amongst children.

One of the most contentious points is whether the school medical service should aim to offer a physical examination and full developmental evaluation to all children, or whether because the yield of new abnormalities is small, only selected children should be examined on the basis of pre-existing problems affecting health or development, or concerns raised by parents or teachers. The importance of audit in all aspects of child health service delivery was also emphasised.

7.18 A More Focussed Service?

Against this background, a strategic review of future directions for child health services in Guernsey has been conducted between the Consultant Community Paediatrician, other senior child health services providers, senior community nursing staff, the Director of Community Services, and the Director of Public Health.

One barrier to defining the most rational deployment of community child health resources continues to be the lack of quantifiable outcome measures of pre school and school based health programmes, and this is an area which still needs to be addressed.

Additionally in Guernsey, many parents apparently value the reassurance given by the present “free” school health service, even when the yield of demonstrated abnormalities is low.

Consideration of possible directions for the future development of child health services in Guernsey must therefore include;

- Better identification and selective resourcing of children and families most likely to benefit from additional support.
- Further development of health promotion programmes in conjunction with the Guernsey Education Council’s Physical, Social and Health Education (PSHE) and the Board of Health’s Health Promotion Unit.
- Further school based health related behaviour surveys such as the 1992 Health Related Behaviour Questionnaire and the 1993 Guernsey Primary Survey conducted by the Schools’ Health Education Unit at the University of Exeter.
- Targeting of health promotion and health education to identified areas of concern including;
 - Smoking behaviour
 - Alcohol consumption
 - Healthy diets
 - Promoting physical activity
 - Substance misuse
 - Contraception and adolescent sexual behaviour

- Better identification and intervention in the childhood antecedents of adult disease eg diabetes mellitus and cardiovascular disease.
- Continued development of child and adolescent mental health services and social support to address problems caused by the changing family and social trends outlined last year in the 96th Annual MOH Report.
- Continuing development of the Schools' Dental Service in the light of accepted best "dental public health" practice.

This may well involve a focussed strategy of oral health promotion, screening and treatment targetted at those of greatest risk.

7.19 Conclusions

It is obviously not possible to consider all aspects of children's health and child health services in Guernsey during this short review. In particular, it is regretted that it has not been possible to devote more space to a consideration of the work of the Health Visitors, School Health Service, the Child Development Centre, and the Child and Adolescent Mental Health Services based at Bell House.

- However, on the evidence presented, significant improvements in the physical health of Guernsey children during infancy, and continuing into later childhood can be demonstrated over the past thirty years.
- There have also been major changes in the social context of childhood, with more women choosing to work, to have fewer children, and to have them later in life than ever before. There has also been a rise in the divorce rate, a rise in single parent families, and in births outside marriage.
- Family dysfunction, and psychosocial stress may contribute to increasing overt psychiatric illness during childhood and adolescence, manifest by increases in depression, self harm, suicide and attempted suicide. A strong case can be made for the re-orientation of child health services to cope with these changing patterns of childhood morbidity.

7.20 The States Consultant Community Paediatrician Comments

States Consultant Community Paediatrician Dr Neil Boyle comments;

"In the current political and financial climate, the acquisition of new resources in the public sector is likely to become increasingly difficult. It therefore becomes ever more important to review and asses the effectiveness of the current child health services provided by the Board of Health and related services. This in turn means greater time and effort must be spent on audit. There are several barriers to effective audit of child health services in Guernsey which must be addressed.

- The relatively small population of children means there may be huge swings in incidence of low frequency disorders such as infant deaths, although statistical techniques like five year means may be helpful. Nevertheless, the incidence of low frequency disorders becomes less valuable as an audit tool.
- Improvement in social and environmental conditions has led to a marked reduction in mortality rates amongst children, therefore limiting their usefulness as indicators of need.

- It follows that improved morbidity information is required but not readily available at present, although some indirectly derived information is beginning to be generated. Extra resources must be committed to the collection of morbidity data - the current development of the child health computer system will contribute to this, although it will be sometime before useful longitudinal data is available.
- There are several areas of childhood morbidity or perceived childhood morbidity which are particularly difficult to measure using standard concepts such as prevalence and incidence. This includes mental illness, particularly where this overlaps with behaviour and conduct disorders.
- Another difficult area is that of parentally perceived illness. This consumes large quantities of medical and nursing time in both primary and secondary care, although these children do not by definition have anything seriously wrong with them. Audit using clearly definable diagnostic headings is thus exceedingly difficult.
- Priority must be given to health initiatives which address childhood antecedence of adult disease. A lot of these will require enhanced “health education”, such as smoking and its long term effects on respiratory and cardiovascular disease, and the influence of lack of exercise on the development of diabetes mellitus in later life.
- Ever since children’s medicine became a identifiable discipline at the beginning of this century, disproportionate amounts of medical and nursing resources have been directed to care for children from deprived social backgrounds. This still continues to be the case, with many of the more recently defined risk factors (such as smoking) being more common amongst the less affluent groups. Disadvantaged groups DO exist in Guernsey - they require increased support which can only be achieved by targeting resources towards them, which of necessity must mean decrease in services elsewhere.

In summary, there is a demonstrated need to;

- Look for newer and more sensitive techniques to audit the effectiveness of our current services.
- Redirect more health professionals time towards audit.
- Share health information across a wide spectrum of services both public and private.
- Prepare the population for possible major changes in the way child health services are delivered.
- Specifically target the use of scarce resources.
- Seek ways of improving health education in the broadest sense of this term.”

8.0 Guernsey - Vital Statistics 1995

8.1 Births and Birth Related Data

	Guernsey		
	1995	5 Year Mean 1989-1993	England & Wales 1994/5
Estimated Mid Year	59,000	58,867	51,620,500
Resident Population:			
• Males (est)	28,600	28,297	25,303,600
• Females (est)	30,870	30,570	26,316,900
• M : F	0.926	0.925	0.96
Population Density [Area 63.1Km²]:	943	933	236 (UK)
Marriages:	352	401	N/A
• Marriages/000	5.92	6.81	5.8
Divorces:	153	173	155,500
• Divorces/000	2.6	2.93	3.0
Divorces : Marriages	0.44	0.43	N/A
Births:	624	725.6	648,138
• Males	306	370.8	334,100
• Females	318	354.8	317,638
• M : F	0.96	1.045	1.052
Births outside marriage:	173	148.2	219,949
• % All Births	27.7%	20.4%	33.9%
Stillbirths:	4	4	3,600
• Rate/100 Live Births	6.4	5.5	5.5
Neonatal Deaths:	1	2.4	5,940
• Perinatal Death Rate	7.9	8.8	8.9
Infant Deaths:	2	4.2	3,968
• Infant Death Rate	3.2	5.7	6.1
Crude Birth Rate:	10.5	12.3	12.6
Natural Fertility Rate:	48.6	53.3	60.4
Natural Increase per annum:	+0.01%	0.20%	0.16%

8.1 Births and Birth Related Data

● Resident Population and Population Density

The population totals given remain “best estimates”, but will be confirmed following the publication of the initial 1996 Census data.

● Marriage and Divorce

Both the number of marriages, and the marriage rate remains roughly consistent with the 1994 figures, but still somewhat below the five year mean.

Divorces and divorce rate have also not shown any increase since 1994. The ratio of divorces to marriage remains steady.

● Births and Births Outside Marriage

The total number of births, the crude birth rate, and the natural fertility rate continue to decline having fallen below 1994 levels, and being the lowest in post war years. Once again, there were fewer ..?.. births than would normally be expected in Guernsey.

Whilst total births fall, the proportion outside marriage continues to rise, showing a 4% increase from 23.7% of all births in 1994 to 27.7% in 1995. This parallels the trend in England and Wales, where births outside marriage also continue to rise.

● Stillbirths, Neonatal and Infant Deaths

There was 4 stillbirths during 1995, all of which were felt to be due to unavoidable causes. No neonatal audit was therefore arranged. Infant deaths however showed a further fall, and the infant death rate is at present the lowest since records have been kept.

Women in Guernsey are choosing to have fewer babies per year, and fewer babies overall than their counterparts in England and Wales.

● Crude Birth and Natural Fertility Rate

This shows a further fall from below the five year mean, and remains significantly below that for England and Wales.

● Natural Increases

The natural increase is the difference between the crude birth and crude death rates expressed as a percentage of the resident population. There were 624 births, and 617 deaths during 1995. The continuing fall in birth rate, combined with a higher than usual number of deaths means that the natural increase in Guernsey is a mere 0.01%. This is the lowest in post-war years, and if these trends were to continue, and migration increases excluded, there would eventually be a decline in the resident population.

8.0 Guernsey - Vital Statistics 1995 (contd)

8.2 Guernsey Deaths and Death Related Data

	Guernsey		
	1995	5 Year Mean 1989-1993	England & Wales 1994/5
Total Deaths:	617	591	565,902
• Males	306	294	272,709
• Females	311	297	293,709
• M : F	0.98	0.99	0.93
Crude Death Rate:	10.4	10.0	11.0
Circulatory Deaths (I00-I99):			
• Males	409	417	459
- Rate/00,000			
• Females	372	402	479
- Rate/00,000			
Cancer Deaths (C00-C97/D00-D48):			
• Males	332	332	291
- Rate/00,000			
• Females	294	255	258
- Rate/00,000			
Lung Cancer Deaths (C34):			
• Males	73.4	101.7	83.5
- Rate/00,000			
• Females	45.4	45.1	41.8
- Rate/00,000			
Breast Cancer Deaths (C50):			
• Females	39.0	41.14	48.8
- Rate/00,000			
Alcoholic Liver Disease (K70):			
• Males	17.5	12.7	8.5
- Rate/00,000			
• Females	3.3	8.4	5.6
- Rate/00,000			
Injury Deaths (S00-X59):			
• Males	31.3	14.1	23.4
- Rate/00,000			
• Females	—	9.2	16.5
- Rate/00,000			
Suicide Deaths (X60-X84):			
• Males	14.0	9.9	11.1
- Rate/00,000			
• Females	13.0	4.6	3.0
- Rate/00,000			

8.2 Guernsey Deaths and Death Related Data

● Changes in Classification Coding

For the first time, Guernsey mortality data has been coded using ICD-10. However, population figures published by the Office of National Statistics (formerly the Office of Population, Censuses and Surveys) are still classified on ICD-9, and therefore may not be strictly comparable. Where there are differences however, these are likely to be small.

● Total Deaths and Crude Death Rate

There were slightly more deaths during 1995 than in recent years, and therefore a slight rise in the crude death rate. This is not felt to be statistically significant. The crude death rate remains lower than England and Wales because of the somewhat younger age structure to the Guernsey population (x% aged 65 and above, compared with y% in England and Wales).

● Deaths from circulatory disease

These remain the commonest cause of deaths amongst both males and females, and remain slightly lower than for England and Wales.

● Cancer Deaths

Cancers (all causes) remain the second leading cause of death amongst both men and women in Guernsey. Rates are slightly higher than for the equivalent population of England and Wales.

There were fewer lung cancer deaths amongst males than in recent years, but a similar rate amongst Guernsey females, who continue to show a higher rate than their counterparts in England and Wales.

Deaths from breast cancer remain around the five year mean, which is somewhat lower than England and Wales.

● Alcoholic Liver Disease

Deaths certified by a doctor as being due to alcoholic liver disease remain high amongst Guernsey males, at a similar level to 1994, and above the five year mean for 1989-1993. There was only 1 female death certified as due to this cause.

● Injury and Suicide Deaths

Deaths from injuries (all causes) were higher than usual during 1995 amongst Guernsey males, but there were no injury deaths amongst Guernsey females.

Similarly, suicide deaths amongst both males and females were high in 1995, but not too much should be read into a single year's statistics.

8.3

Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total M F	Under 1 M F	Age 1-14 M F	Age 15-24 M F	Age 25-44 M F	Age 45-64 M F	Age 65-74 M F	Age 75+ M F
	Group 1								
	Infectious & Parasitic Diseases								
A15	Respiratory tuberculosis bacteriologically & histologically confirmed	- 1	- -	- -	- -	- -	- -	1 -	- -
A41	Other septicaemia	1 -	- -	- -	- -	- -	- -	- -	1 -
B23	Human immunodeficiency virus [HIV] disease resulting in other conditions	1 -	- -	- -	- -	1 -	- -	- -	- -
	totals group 1	2 1	- -	- -	- -	1 -	- -	1 -	1 -
	Group 11								
	Neoplasms								
C09	Malignant neoplasm of tonsils	1 -	- -	- -	- -	- -	1 -	- -	- -
C11	Malignant neoplasm of nasopharynx	1 1	- -	- -	- -	- -	- -	1 -	- 1
C15	Malignant neoplasm of oesophagus	6 6	- -	- -	- -	- -	1 1	2 2	4 3
C16	Malignant neoplasm of stomach	5 4	- -	- -	- -	- -	1 1	1 1	3 2
C18	Malignant neoplasm of colon	10 4	- -	- -	- -	- -	- -	1 1	9 4
C20	Malignant neoplasm of rectum	3 4	- -	- -	- -	- 1	1 -	1 1	1 2
C22	Malignant neoplasm of liver & Intrahepatic bile ducts	3 2	- -	- -	- -	- -	1 1	2 1	- -
C25	Malignant neoplasm of pancreas	3 7	- -	- -	- -	1 -	- 4	- -	- 3
C26	Malignant neoplasm of other & ill-defined digestive organs	1 1	- -	- -	- -	- -	1 1	- -	- -
C32	Malignant neoplasm of larynx	2 -	- -	- -	- -	- -	1 -	1 -	- -
C34	Malignant neoplasm of bronchus & lung	21 14	- -	- -	- -	- -	8 4	4 5	9 5
	carried forward	56 43	- -	- -	- -	1 1	15 12	12 10	28 20

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	brought forward	56	43	-	-	1	-	-	-	1	1	14	12	12	10	28	20
C44	Other malignant neoplasms of skin	-	3	-	-	-	-	-	-	-	-	-	-	-	1	-	2
C50	Malignant neoplasm of breast	-	12	-	-	-	-	-	-	-	-	-	2	-	3	-	7
C53	Malignant neoplasm of cervix uteri	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-
C56	Malignant neoplasm of ovary	-	6	-	-	-	-	-	-	-	-	-	3	-	-	-	3
C61	Malignant neoplasm of prostate	14	-	-	-	-	-	-	-	-	-	4	-	2	-	8	-
C64	Malignant neoplasm of kidney, except renal-pelvis	2	1	-	-	-	-	-	-	-	-	1	-	-	-	1	1
C65	Malignant neoplasm of renal pelvis	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
C67	Malignant neoplasm of bladder	5	3	-	-	-	-	-	-	-	-	-	-	2	-	3	3
C71	Malignant neoplasm of brain	2	2	-	-	-	1	-	-	-	-	1	1	1	-	-	-
C76	malignant neoplasm of other and ill-defined sites	1	2	-	-	-	-	-	-	-	-	-	1	-	-	1	1
C78	Secondary malignant neoplasm of respiratory & digestive organs	-	2	-	-	-	-	-	-	-	-	-	-	-	1	-	1
C79	Secondary malignant neoplasm of other sites	7	13	-	-	-	-	-	-	-	-	-	1	2	3	5	9
C81	Hodgkin's disease	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-
C84	peripheral, cutaneous T-cell lymphomas	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
C90	Multiple myeloma and malignant plasma cell neoplasms	2	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-
C92	Myeloid leukaemia	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
C93	Monocytic leukaemia	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
D46	Myelodysplastic syndromes	3	1	-	-	-	-	-	-	-	-	-	-	3	1	-	-
	totals group 11	95	91	-	-	1	1	-	-	1	1	22	22	23	19	48	48

8.3.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total	Under 1	Age 1-14	Age 15-24	Age 25-44	Age 45-64	Age 65-74	Age 75+
		M F	M F	M F	M F	M F	M F	M F	M F
	Group 111								
	<u>Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism</u>								
D59	Acquired haemolytic anaemia	- 1	-	-	-	-	-	-	- 1
D61	Other aplastic anaemias	- 1	-	-	-	-	-	- 1	-
	totals group 111	- 2	-	-	-	-	-	- 1	- 1
	Group IV								
	<u>Endocrine, nutritional & metabolic diseases</u>								
E10	Insulin-dependent diabetes mellitus	- 1	-	-	-	-	-	- 1	-
E13	Other specified diabetes	- 3	-	-	-	-	- 2	-	- 1
E14	Unspecified diabetes mellitus	2 2	-	-	-	1	-	-	1 2
	totals group IV	2 6	-	-	-	1	- 2	- 1	1 3
	Group V								
	<u>Mental & Behavioural disorders</u>								
F00	Dementia in alzheimer's disease	2 6	-	-	-	-	-	-	2 6
F03	Unspecified dementia	3 3	-	-	-	-	-	-	3 3
	totals group V	5 9	-	-	-	-	-	-	5 9

8.3.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	<u>Group VI</u> <u>Diseases of the nervous system</u>																
G20	Parkinson's disease	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
G64	Other disorders of the nervous system	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
G71	Primary disorders of muscles	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
	totals group VI	2	1											1		1	1
	<u>Group IX</u> <u>Diseases of the circulatory system</u>																
I05	Rheumatic mitral valve disease	1	1	-	-	-	-	-	-	-	-	1	-	-	-	1	-
I06	Rheumatic aortic valve disease	3	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-
I08	Multiple valve disease	1	1	-	-	-	-	-	-	-	-	-	-	-	-	1	1
I11	Hypertensive heart disease	6	4	-	-	-	-	-	-	-	-	2	-	1	-	3	4
I12	Hypertensive renal disease	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
I15	Secondary hypertension	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
I20	Angina pectoris	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
I21	Acute myocardial infarction	28	12	-	-	-	-	1	-	-	-	2	1	5	2	20	9
I25	Chronic ischaemic heart disease	43	39	-	-	-	-	-	-	-	-	5	1	11	3	27	35
I26	Pulmonary embolism	1	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1
I35	Nonrheumatic aortic valve disorders	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	2
I42	Cardiomyopathy	2	1	-	-	-	-	-	-	-	-	2	-	-	-	-	1
I48	Atrial fibrillation and flutter	1	2	-	-	-	-	-	-	-	-	-	-	-	-	1	2
I50	Heart failure	7	9	-	-	-	-	-	-	-	-	-	-	-	-	7	9
I61	Intracerebral haemorrhage	2	8	-	-	-	-	-	-	-	-	1	-	-	-	1	6
	carried forward	96	82	-	-	-	-	-	-	-	-	14	3	17	7	64	72

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	brought forward	96	82	-	1	-	-	1	-	-	-	14	3	17	7	64	71
I63	Cerebral infarction																
I64	Stroke, not specified as haemorrhage or infarction	5	1	-	-	-	-	-	-	-	-	-	-	1	-	4	1
I67	Other cerebrovascular diseases	1	9	-	-	-	-	-	-	-	-	-	-	-	-	1	9
I70	Atherosclerosis	4	11	-	-	-	-	-	-	-	-	-	-	1	-	3	11
I71	Aortic aneurysm & dissection	2	3	-	-	-	-	-	-	-	-	1	1	1	1	1	1
I72	Other aneurysm	7	3	-	-	-	-	-	-	-	-	-	-	2	1	5	2
I73	Other peripheral vascular diseases	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
I74	Arterial embolism & thrombosis	1	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1
I82	Other venous embolism & thrombosis	-	4	-	-	-	-	-	-	-	-	-	-	1	-	-	-
	total group IX	117	115	-	1	-	-	1	-	-	-	15	5	23	10	78	99
	Group X																
	<u>Diseases of the respiratory system</u>																
J10	Influenza due to identified influenza virus	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
J11	Influenza virus not identified	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	2
J12	Viral pneumonia, not elsewhere classified	1	1	-	-	-	-	-	-	-	-	-	-	-	-	1	1
J15	Bacterial pneumonia, not elsewhere classified	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
J17	Pneumonia in diseases classified elsewhere	-	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-
	carried forward	2	5	-	-	-	-	-	-	-	1	1	-	-	-	1	4

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	brought forward	2	5	-	-	-	-	-	-	-	1	1	-	-	-	1	4
J18	Pneumonia, organism unspecified	18	32	-	-	-	-	-	-	-	-	-	-	2	2	16	30
J21	Acute bronchiolitis	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
J39	Other diseases of upper respiratory tract	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
J40	Bronchitis, not specified as acute or chronic	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
J41	Simple & mucopurulent chronic bronchitis	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
J42	Unspecified chronic bronchitis	4	1	-	-	-	-	-	-	-	-	-	-	-	-	4	1
J43	Emphysema	3	2	-	-	-	-	-	-	-	-	-	1	2	-	1	1
J44	Other chronic obstructive pulmonary disease	17	8	-	-	-	-	-	-	-	-	2	-	8	2	7	6
J47	Bronchiectasis	1	2	-	-	-	-	-	-	-	-	-	-	1	-	-	2
J84	Other interstitial pulmonary diseases	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
J96	Respiratory failure, not elsewhere classified	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
	total group X	48	53	-	-	-	-	-	-	-	1	3	1	13	4	32	47
	Group X1																
	<u>Diseases of the digestive system</u>																
K20	Oesophagitis	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
K22	Other diseases of the oesophagus	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
K25	Gastric ulcer	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
	carried forward	3	-	-	-	-	-	-	-	-	-	-	-	1	-	2	-

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	brought forward	3	-	-	-	-	-	-	-	-	-	-	-	1	-	2	-
K26	Duodenal ulcer	2	1	-	-	-	-	-	-	-	1	-	-	1	-	1	-
K38	Other diseases of appendix	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
K55	Vascular disorders of intestine	1	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1
K56	Paralytic ileus & intestinal obstruction without hernia	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
K57	Diverticular disease of intestine	-	1	-	-	-	-	-	-	-	-	-	-	-	1	1	-
K65	Peritonitis	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
K70	Alcoholic liver disease	5	1	-	-	-	-	-	2	-	-	1	-	-	-	-	-
K74	Fibrosis & cirrhosis of liver	2	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-
K81	Cholecystitis	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
K85	Acute pancreatitis	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
K92	Other diseases of digestive system	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
	total group XI	16	8	-	-	-	-	-	4	1	1	2	1	2	2	7	4
	Group XIII																
	Diseases of the musculoskeletal system & connective tissue																
M05	Seropositive rheumatoid arthritis	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
M30	Polyarteritis nodosa & related cond.	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
M34	Systemic sclerosis	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
M35	Other systemic involvement of connective tissue	-	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-
M81	Osteoporosis without pathological fracture	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
	totals group X111	2	3	-	-	-	-	-	1	-	-	1	-	1	1	-	2

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total M F	Under 1 M F	Age 1-14 M F	Age 15-24 M F	Age 25-44 M F	Age 45-64 M F	Age 65-74 M F	Age 75+ M F
	<u>Group XIV</u> <u>diseases of the genitourinary system</u>								
N10	Acute tubulo-interstitial nephritis	1 -	- -	- -	- -	- -	- -	- 1	- -
N18	Chronic renal failure	1 3	- -	- -	- -	- -	- 2	- 1	- 1
N19	Unspecified renal failure	1 1	- -	- -	- -	- -	- -	- 1	- 1
N39	Other disorders of urinary system	- 2	- -	- -	- -	- -	- 1	- -	- 1
	totals of group XIV	3 6	- -	- -	- -	- -	- 3	- 3	- 3
	<u>Group XVI</u> <u>Certain conditions originating in the</u> <u>perinatal period</u>								
P70	Transitory disorders of carbohydrate metabolism specific to fetus & newborn	1 -	1 -	- -	- -	- -	- -	- -	- -
	total group XVI	1 -	1 -	- -	- -	- -	- -	- -	- -
	<u>Group XVII</u> <u>Congenital malformations of the</u> <u>nervous system</u>								
Q00	Anencephaly & similar malformations	- 1	- 1	- -	- -	- -	- -	- -	- -
	total group XVII	- 1	- 1	- -	- -	- -	- -	- -	- -

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total	Under 1	Age 1-14	Age 15-24	Age 25-44	Age 45-64	Age 65-74	Age 75+
		M F	M F	M F	M F	M F	M F	M F	M F
	Group XV111								
	Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified								
R06	Abnormalities of breathing	1	-	-	-	1	-	-	-
R54	Senility	-	-	-	-	-	-	-	-
R68	Other general symptoms & signs	-	-	-	-	-	-	-	-
R99	Other ill-defined & unspecified causes of mortality	-	-	-	-	-	-	-	-
	total group XV111	1	-	-	-	1	-	-	-
	Chapter X1X	1	-	-	-	1	-	-	-
	Injury, Poisoning & certain other consequences of external causes								
S09	Other unspecified injuries of head	1	-	-	-	-	-	1	-
S72	Fracture of femur	1	-	-	-	-	-	-	-
T52	Toxic effect of organic solvents	1	-	-	1	-	-	-	-
T58	Toxic effect of carbon monoxide	1	-	-	-	-	1	-	-
	totals group XIX	4	-	-	1	-	1	-	-
	Group XX								
	External causes, morbidity & mortality								
V29	Motorcycle rider injured in other & unspecified transport accidents	1	-	-	-	-	-	-	1
W74	Unspecified drowning & submersion	2	-	-	1	1	-	-	-
W76	Other accidental hanging & strangulation	1	-	-	-	-	-	1	-
	carried forward	4	-	-	1	1	-	1	-

8.3 contd: Guernsey - Deaths by ICD 10 Codes & Age Groups - 1995

ICD Code No.	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
X09	brought forward Exposure to unspecified smoke, fire & flames Intentional self-harm by hanging, strangulation & suffocation Intentional self-harm by drowning & submersion Drowning & submersion, undetermined event Other specified events, undetermined intent	4	-	-	-	-	-	1	-	1	-	-	-	1	-	1	-
X70		1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
X71		2	1	-	-	-	-	1	1	-	-	1	-	-	-	-	-
Y21		-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Y33		1	2	-	-	-	-	-	-	1	-	-	1	-	-	-	-
		1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
	totals group XX	9	4	-	-	-	-	3	2	2	-	1	1	1	1	2	-

8.4 Alderney Vital Statistics

	Males	Females	Total 1995	Total 1994
Population (1991 Census):	1109	1188	2297	2297
• M : F			0.93	0.93
Births - In Guernsey:	10	12	22	25
- Outside marriage:	4	8	12	5
Births - In Alderney:	0	0	0	3
Total Births to Alderney Residents:	10	12	22	28
Marriages Registered in Alderney:			7	17
Deaths Registered in Alderney:	18	15	33	27
Natural Increase:		1 (0.4%)		

9.0 STAFF PROVIDING PUBLIC HEALTH SERVICES 1995/96

Director of Public Health/Medical Officer of Health

Dr David Jeffs MB MRCP MFPMM FRACGP FAFPHM
DCH DObst RCOG FRSH

Personal Assistant

Mrs Maureen Indge

Data Clerk

Mrs Carol Gaskell

Part-time Medical Staff:

Deputy Medical Officer of Health

Dr Brian Parkin MB BS BSc MRCP MRCGP DRCOG

Sexually Transmitted Diseases Clinic

Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer

Mr Michael Bairds MCIEH FRSH MRIPHH

Deputy Chief Environmental Health Officer

Mr John Cook MCIEH AMIA

Environmental Health Officers

Mr Stan Horton MCIEH

Mr Tony Rowe MCIEH

Mr Stephen Smith MCIEH (1995/part 1996)

Mr Stuart Wiltshire MCIEH

Technical Assistant

Mr Simon Penney

Pest Control Operatives

Mr Peter Durham

Mr Paul Tostevin

Secretary

Mrs Angela Ravenscroft (1995)

Mrs Marilyn Bougourd (1995/96)

Health Promotion Unit:

Health Promotion Officer

Miss Yvonne Le Page BEd(Hons) DipHE&HP RHPS

Assistant Health Promotion Officer

Mrs Gerry Grange RGN LAY Trainer RHPS

Resources Officer

Mrs Pat Prevel

Secretary

Mrs Diana Reade

Occupational Health:

Clinical Medical Officer

Dr Helen Gibson MB BS MRCOG (until January 1996)

Dr Ian Gee MB BS MRCP (from February 1996)

Occupational Health Nurse

Mrs Pam Smith RGN OHN

